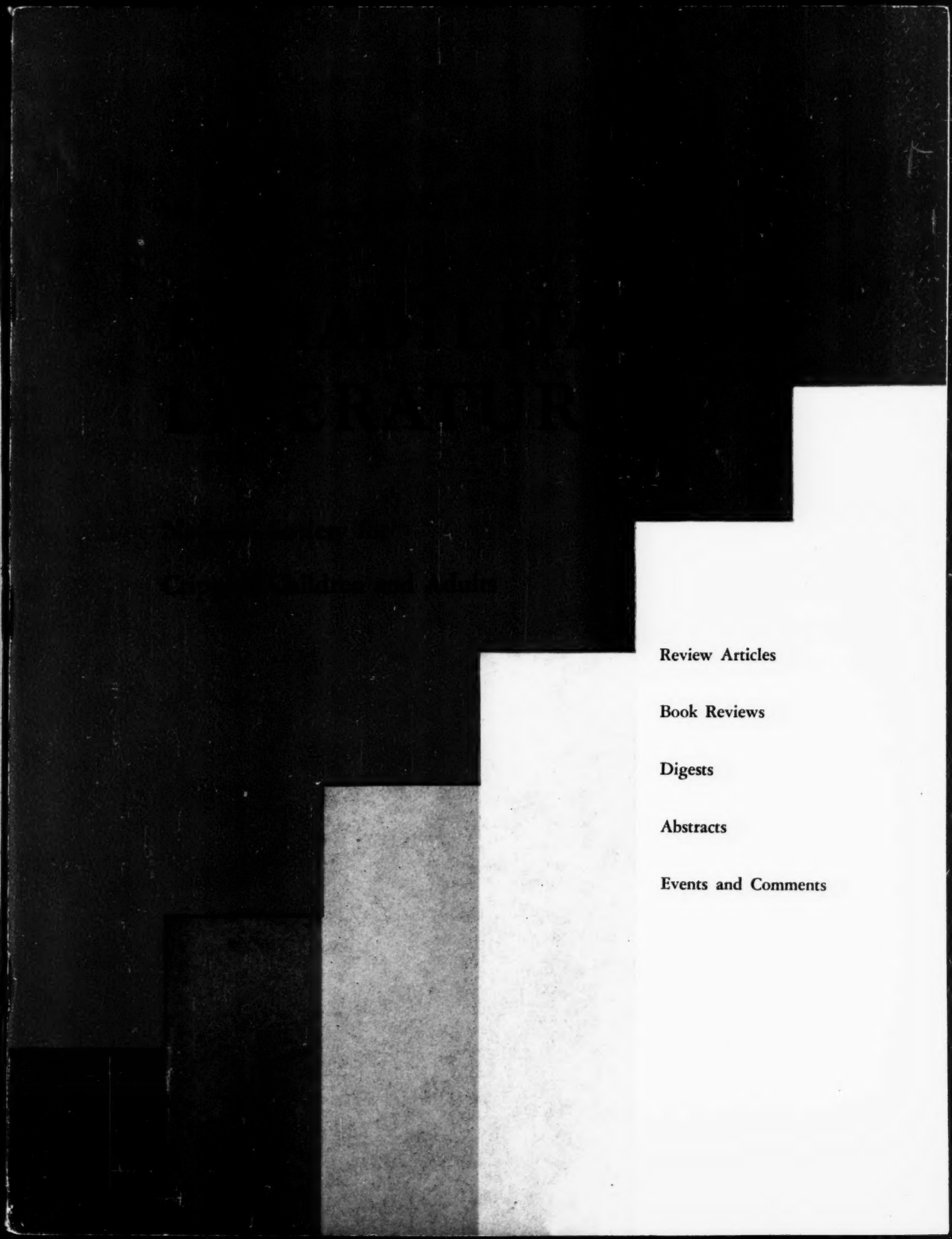
Review Articles
Book Reviews
Digests
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Events and Comments

Rehabilitation Literature is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of co-operative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

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Books for review and correspondence relating to feature articles and other editorial matters should be addressed to the editor. He will welcome your suggestions.

REHABILITATION LITERATURE

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REHABILITATION LITERATURE

Article of the Month

The Deaf-Blind in the United States

Their Care, Education, and Guidance

Daniel J. Burns

and

Gertrude M. Stenquist

About the Authors . . .

Mr. Burns, head of the department for deaf-blind children, Perkins School for the Blind, since 1955, is also lecturer for Boston University School of Education. Mr. Burns is president of the Massachusetts Institutional Chapter, Council for Exceptional Children, and chairman of research, Massachusetts Speech and Hearing Association. He holds membership in the New England Speech and Hearing Association, Conference of Executives of American Schools for the Deaf, American Association of Instructors of the Blind, Alexander Graham Bell Association for the Deaf, and American Association of Instructors of the Deaf. Mr. Burns is a graduate of the State University of New York, Teachers College, Geneseo (B.Ed. 1948, M.S. 1956) and earned his M.A. (1950) from Gallaudet College.

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This original article was written especially for Rehabilitation Literature.

Introduction

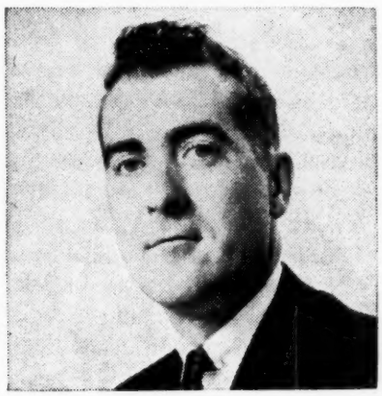
SINCE 1837, THE YEAR Laura Bridgman arrived at Perkins School for the Blind, the public has increasingly recognized problems concerning the deaf-blind, a segment of society small in size but needing many services. This awakened awareness is now more universal than ever; its results are seen in many areas involving those both visually and auditorially handicapped. Education, inspired by the effort and success of Dr. Howe with Laura,[12, 19, 31] is being undertaken with more confidence and better knowledge of methodology; diagnostic, medical, and psychological aspects are being investigated; guidance and rehabilitation are augmenting the self-respect, independence, and economic status of the adults in this group. Services for deaf-blind children and adults are in varying stages of development, and the people providing them are constantly seeking improved technics in the effort to bring about equality of opportunity and the fullest possible participation of the individual in society.

In comparison with services available to some handicapped groups, there is a lack in regard to the deaf-blind, a lack related to the incidence of deaf-blindness. Dr. Edward J. Waterhouse, Director of Perkins School for the Blind, commented on the significance of this factor:

Fortunately, the number of deaf-blind persons is relatively small. This good fortune is for the many who have been spared the loss of these two senses, for the very smallness of the group intensifies the problems of those within it. If there were as many deaf-blind persons as there are

Gertrude M. Stenquist

Daniel J. Burns



deaf or blind or crippled, then programs, both of services and of research, comparable to those that exist for these larger groups, would no doubt have long since been established for the deaf-blind also.[42 (p. 7)]

In the last decade more organized effort has been aimed at providing services for the deaf-blind. "Whether it will ever be possible to say that every deaf-blind man, woman, and child who has ability and the wish to participate in his community life is doing so, or whether this continues to be a hope over coming generations, it is good to know that the work has begun." [50 (p. 6)]

We wish to report on this work being done on behalf of those whom Helen Keller has described as "a comparatively few people surrounded by a multitude of cruel problems."[23] We are concerned with the evaluation and education of children and with the training of teachers, a valuable and important part that is but a piece in the total mosaic, a large design worked upon by many people.

The Deaf-Blind Population

The department of Services to the Deaf-Blind at the American Foundation for the Blind, gives the over-all picture of the deaf-blind in the United States as of January 1, 1960, as:

Total number of children (under 20 years of age) . . 372
- Children being educated in deaf-blind departments. 87
- Children at home 190
  - 4 years of age and under 22
  - 5-19 years of age 168
  - (Some of these have been in deaf-blind departments; some have never been in school.)
- Children in institutions for the mentally retarded . . 74
- Children in nursery school or a tutorial situation . . . 21

Total number of adults (over 20 years of age) . *3,300-3,400*

Few of the 372 children listed on the Foundation register are totally blind and profoundly deaf. In fact, in 1953 it was reported that: ". . . only one-fourth to one-third of them are totally deaf and totally blind, while a smaller proportion yet have been so since birth. The highest percentage seem to be those who have been deaf from birth, *i.e.*, unable to acquire speech and language through hearing, with a partial loss of vision."[11 (p. 7)] A recent checking of the register indicates that 40 percent or more of these children have at least one other physical disability such as cerebral palsy, brain damage without cerebral palsy, or congenital heart defect.

The National Study Committee on the Education of Deaf-Blind Children gives this broad definition: "A deaf-blind child is one whose combination of handicaps prevents him from profiting satisfactorily from educational programs provided for the blind child or the deaf child."[30 (p. 28)] This, of course, has major implications for education.

The department of Services to the Deaf-Blind, American Foundation for the Blind, has a "watching list" of children with combined visual and auditory handicaps who may never need the type of education provided in a deaf-blind department but who may some day be special problems for rehabilitation. Although all adults registered with the Foundation are either totally or "legally" blind, not all are profoundly deaf. Actually, over half the number are "hard-of-hearing," but some of these may eventually become profoundly deaf.

Organizations and Committees Concerned with the Deaf-Blind

The American Foundation for the Blind

The American Foundation for the Blind inaugurated their Services to the Deaf-Blind in January, 1946. This department, directed by Annette B. Dinsmore, program specialist, assisted by Betty G. Riley as field worker, "seeks out all deaf-blind persons throughout the country, and studies and promotes services for their personal, social, and economic rehabilitation."[2 (p. 7)] It works closely with state and local agencies and educators, providing consultation to families and individuals through correspondence and personal contacts. Upon application from rec-

ognized agencies, it often furnishes such equipment and appliances as hearing aids, braillewriters, and braille watches for the needy deaf-blind. It defrays tuition for children in special schools pending legislation in their respective states. It awards scholarships for higher education of deaf-blind students and for further education of teachers of the deaf-blind. The Foundation maintains the previously mentioned register of deaf-blind children and adults reported in the United States.

Recognizing the shortage of trained teachers of the deaf-blind as a significant problem, the Foundation joined the Perkins School in sponsoring experimental summer training courses in 1949, 1950, and 1951 at the Horace H. Rackham School of Special Education, Michigan State Normal College, Ypsilanti, Mich.[11 (p. 2)] Also, the Foundation and Perkins School played a major role in forming the National Study Committee on Education of Deaf-Blind Children and in its subsequent work.[30]

In June, 1955, in co-operation with the National Study Committee, the Foundation sponsored a Workshop for Teachers of Deaf-Blind Children at the American School for the Deaf, Hartford, Conn.[4] In February, 1956, a four-day Workshop on Vocational Training and Employment of Deaf-Blind Adults was held at the Foundation headquarters in New York City[3] and in the summer of 1958 a Workshop in the Education and Development of the Preschool Deaf-Blind Child at Syracuse University.

In February, 1957, within the Center for the Development of Blind Children at Syracuse University, a diagnostic clinic was established for observation of multiple-handicapped blind children.[34] The American Foundation for the Blind, working closely with the Center, has as of July 1, 1960, referred 20 deaf-blind children to the clinic. Costs involved in these studies have been assumed in full or in part by the Foundation, which maintains a fund for diagnostic evaluation of deaf-blind children. Research is planned on employability of deaf-blind adults. The numbers employed, in need of rehabilitation, at home, and in homes for the aged will be investigated.

The numerous publications of the Foundation include some primarily concerned with the deaf-blind. The booklet dealing with problems and methods of communication[10] is outstanding. Reports of the Hartford[4] and New York[3] workshops and of the Syracuse project[34] are also of major interest.

In conclusion, it is significant to note that Helen Keller has been an active supporter of the Foundation from its inception. She is now serving as counselor in national and international relations.

The Industrial Home for the Blind, New York

The Industrial Home for the Blind, founded in 1893, is one of the oldest and largest agencies for the adult blind. Its early workshop and resident services were instrumental in awakening the public to a broader concept of blindness. By 1920 it was possible to begin adding various other service programs. The program is now extensive and "has been made available to blind residents of the four counties of Long Island; and, upon application from a recognized agency, to blind individuals from other communities throughout the country if there are no similar services available there or if it is felt that our service can be of special benefit to the individual client. . . . Because of the scarcity of programs for the deaf-blind throughout the country the IHB has offered these services (to the deaf-blind) more liberally than would otherwise be justifiable."[20 (1, p. 5)]

The preceding quotation manifests the interest taken by the Home in deaf-blind adults, an interest that originated with the effort and success of Dr. Peter J. Salmon, who joined the staff in 1917 and became executive director in 1929, in fitting an ever-increasing number of deaf-blind men into the program designed for the blind. By 1940 there were 15 deaf-blind men in the workshop. On June 27, 1945, Helen Keller's birthday, a department for the deaf-blind was established.[20 (1, p. 6)] The pioneering work of this organization in the rehabilitation of adult deaf-blind persons has resulted in improved concepts and conditions. Deaf-blind persons have been found capable of doing varied jobs in the special workshops of the Industrial Home for the Blind. At present a deaf-blind man, Robert Smithdas[37] "occupies a professional position on the staff of the Industrial Home for the Blind in Brooklyn."[42 (p. 15)]

It is interesting to note that very soon after the inception of this local program the department of Services to the Deaf-Blind of the American Foundation for the Blind began functioning at a national level. The two departments have continued to co-operate closely.

Of tremendous import to the welfare of deaf-blind adults is a pilot study completed in 1958[36] by the U.S. Office of Vocational Rehabilitation, and the Industrial Home for the Blind. It is reported in seven volumes entitled *Rehabilitation of Deaf-Blind Persons.*[20] The first is a manual for professional workers with deaf-blind persons, a summary report of the entire study containing an extensive bibliography on the subject of the deaf-blind. The next five volumes discuss in detail communication, medical studies, psychological studies, vocational adjustment, and recreation in regard to the adult deaf-blind. The final volume surveys selected social characteristics of deaf-blind adults in New York state in the fall of 1957.

According to Dr. Waterhouse—

These books do show that much can be done for deaf-blind persons. In certain areas a considerable amount is being done now. Almost any rehabilitation or welfare agency could do a good deal for a deaf-blind client with no more assistance than the knowledge these volumes impart. While these books are, in a sense, a monument to the work accomplished in the last 30 or more years at the Industrial Home for the Blind, and a special tribute

to the leadership given his fine staff by Dr. Salmon, more than anything they are a challenge to assist in helping solve the problems of people who are both deaf and blind.[39] (p. 32)

Committee on Services for the Deaf-Blind

In Paris, in 1954, the World Council for the Welfare of the Blind established a Committee on Services for the Deaf-Blind. The Committee, under the chairmanship of Peter Salmon, was given two assignments: 1) to study various methods of communication used by the deaf-blind and to establish an international manual alphabet for this group; 2) to develop a basic minimum service proposal for deaf-blind persons.

The Committee reported its findings to the World Assembly of the World Council for the Welfare of the Blind at Rome, Italy, in 1959. This extensive report has been published in a volume dedicated to deaf-blind women throughout the world.[50] Part I is concerned with communication, "the key to any rehabilitative procedure, and certainly the key to the success we seek in bringing this group into fuller participation in community affairs."[20] (I, p. 3) The Committee recommends as an international standard manual alphabet for deaf-blind persons the use of block Roman letters printed with firm bold strokes on the palm of the receiver's hand. Part II proposes minimal services for deaf-blind adults in the areas of understanding, communication, work, recreation, and consultative services. Included in the volume are specific suggestions for the helper of deaf-blind persons, a report of the conference on communication held by the committee in 1957 in New York, and other pertinent monographs.

The reading of this report and of the previously mentioned seven volumes is recommended to all who wish to know of the latest developments in regard to the adult deaf-blind. We also recommend their reviews.[39]

The National Study Committee on Education of Deaf-Blind Children

A Conference of Educators of Deaf-Blind Children, held at Perkins School in April, 1953,[9] was sponsored by the School and the American Foundation for the Blind and attended by educators of the deaf and of the blind and by representatives of the U.S. Office of Education. The Conference discussed such problems as lack of facilities for the education of the deaf-blind children and need for research and for teachers. As part of the attack on problems concerning the deaf-blind, the National Study Committee on Education of Deaf-Blind Children [30, 44] was formed, consisting of committees (already formed in 1952 to study problems of the deaf-blind on a nationwide basis) of the American Association of Instructors of the Blind and of the Conference of Executives of American Schools for the Deaf, together with representatives of schools with special departments for the deaf-blind and of the American Foundation for the Blind.

The Committee first met in Washington, D. C., in July, 1953, and later at Council Bluffs, Iowa, in January, 1954,[30] at Louisville, Ky., in November, 1954, at Lansing, Mich., in March, 1956, and at the American Foundation for the Blind in New York in April, 1957. The executive board of the Committee met at Perkins School for the Blind, in October, 1958. Dr. Waterhouse, secretary of the Committee, reported: "Since the last meeting on the subject of the deaf-blind in Watertown, five years ago, the number of deaf-blind children being educated throughout the country has increased about fifty percent. Each year there is a small growth, both in the number of pupils and in the number of available trained teachers. There is still much need for expansion, and the chief, but by no means the only, obstacle to rapid growth is the limited number of young men and women who are qualified to engage in this highly-specialized work."[44] (p. 7)

In June, 1955, this Committee co-operated with the American Foundation for the Blind in sponsoring a Workshop for Teachers of Deaf-Blind Children.[4] Mr. M. Robert Barnett, executive director of the Foundation, has called this workshop "a milestone in that for the first time educators concerned with this group met and discussed their total problems."[5] Teachers from the various departments for deaf-blind children, together with Miss Annette B. Dinsmore and other personnel of the Foundation, discussed such topics as readiness for school, parent counseling, teaching methods, and evaluation.

Education

History

The beginnings of the education of deaf-blind children in the United States center about two deaf-blind children and their teachers. With the tutoring of Laura Bridgman by Dr. Samuel Gridley Howe at Perkins, the education of the deaf-blind began over a century ago. Working from a basic knowledge of methods used by European educators of the deaf, Dr. Howe developed his own method of teaching and was successful in educating Laura through a manual means of communication. This occasion was given international publicity by Charles Dickens in his *American Notes* after he visited Perkins and became acquainted with Dr. Howe's work with his deaf-blind pupil.

Dr. Howe's achievements with Laura Bridgman gave the initial impetus to an interest in, and to a more helpful attitude toward the teaching of deaf-blind children in the United States and throughout the world. But perhaps the most instrumental force in furthering this interest and optimism was the successful education of Helen Keller by Anne Sullivan Macy.

Miss Sullivan, a graduate of Perkins, tutored Helen at her home in Alabama and accompanied her on a two year visit to Perkins. Miss Sullivan developed her methods from a knowledge of Dr. Howe's scrupulously kept records of his work with Laura Bridgman and from a knowledge of children, of blindness and of deafness gleaned through a perceptive and persistently inquiring mind. Helen was

instructed by means of the manual alphabet. However, later in her life she became aware of the achievement of a deaf-blind Norwegian girl, Ragnhild Kaata, who had learned to communicate orally, and was determined to learn to do so herself. In her achievement, Miss Keller remains an inspiration to all who are interested in the deaf-blind and their problems.[7] (69/1)

After Laura and Helen,[21] many deaf-blind children were educated at Perkins and elsewhere with varying degrees of success.[14, 15, 16, 35, 40] The year 1931 marked a revolutionary change, for then Dr. Gabriel Farrell, director of Perkins School and originator of the appellation "Children of the Silent Night,"[13] organized the teaching of the deaf-blind at Perkins under a special department in charge of Inis B. Hall. Miss Hall gave her teachers, mainly people experienced in teaching the deaf, "on-the-job training" and the deaf-blind department grew gradually. In 1940-41, 18 pupils were enrolled but, due to a lack of teachers during and after the war, it grew necessary to curtail admission.[46] (p. 36)

When Dr. Waterhouse became director in 1951 the pendulum began to swing the other way. After a thorough study of problems, especially teacher shortage and the need for research as to methods of evaluation, Dr. Waterhouse's report to the trustees convinced them that the program for the deaf-blind at Perkins should be revitalized with emphasis on three areas: educating deaf-blind children; training teachers; performing research in education. This department has expanded and is now functioning at a higher level than ever before in teaching methods, evaluating procedures, and teacher training.

The educational picture was improving elsewhere in the United States. In 1953, there were 5 schools including Perkins with departments for deaf-blind children, with a total enrollment of 42 pupils. In 1960 there are 8 schools with 87 pupils enrolled. These schools and their enrollments are as follows:

*Alabama Institute for the Deaf and Blind	15
California State School for the Blind	8
Illinois Braille and Sight Saving School	8
Iowa State School for the Deaf	2
Michigan School for the Blind	7
*New York Institute for the Education of the Blind	12
*Perkins School for the Blind	29
*Washington State School for the Blind	6
Total	87

*Accepts children from other states.

The Deaf-Blind Department at Perkins School for the Blind

Staff.—The 37 adults whose services are required in the education and care of the 29 children in the department are: a department head, supervising teacher, research worker, curriculum co-ordinator, department secretary, department maid, teachers, teachers-in-training, and attendants. The services of many departments within the school are often needed. For example, children often attend classes such as swimming, cooking, ceramics, weaving, woodworking, and physical education in the school for the blind.

Keller-Macy Cottage.—The schooling of the children, except for the special activities named above, is conducted mainly in one building, the Keller-Macy Cottage,[43] which Helen Keller dedicated in November, 1956, in honor of herself and Anne Sullivan Macy,[6, 26] her famous teacher and Perkins graduate.

Socialization.—To provide for socialization,[47] the deaf-blind are in cottages with blind children of their own age group. There they sleep, eat, play, and enter into the many activities of the cottage family plan.

Curriculum.—Due to the department's rapid growth and the wide range of student differences, curriculum development was urgently needed, particularly at the preacademic and early academic levels. During the past year, a beginning was made in a readiness program[33] focusing upon the over-all social development of the children during their first years at Perkins as preparation for actual academic beginnings. The program has sections on socialization or emotional growth, self-care, motor functioning, self-occupation (play), and intellectual functioning, including development of auditory, visual, tactual, and olfactory perception, language building, creative experience, and communication. While emphasizing the development of social adequacy and intellectual development, study guides for teachers will be designed for the various facets of academic training, extending to levels at which curricula for the deaf, with some adaptations in presentation and technics for the blind, can be followed with ease.

Teacher Training.—In September, 1956, Perkins established a training program for teachers of the deaf-blind,[8] the first to be offered at the graduate level and presently the only one of its type. Each year there have been about five teachers in training. The course of study, which includes the Teaching of Speech to the Deaf and Deaf-Blind with Emphasis on Vibration, the Teaching of Language to the Deaf and Deaf-Blind, and Methods of Teaching the Deaf and Deaf-Blind, is part of the program of special education offered for graduate credit at Boston University and can lead to a master's or doctor's degree.

Evaluation and Research.—This paper subsequently presents detailed discussion of the concern at Perkins with these two important areas of the total approach to the problems of the deaf-blind, evaluation and research.

Public Education.—At present a sound and color film about the education of deaf-blind children is being produced. It is hoped to be of value in the education of the public, the encouragement of parents of deaf-blind children, and the recruitment of teachers.

Questionnaire

In March, 1960, a questionnaire was sent to superintendents of schools having special departments for deaf-blind children. Information as of January 1, 1960, was requested concerning pupils, staff, curriculum, methods of communication and instruction, evaluation, guidance, costs, problems, and plans for the future. The most significant information is presented here. In this article we shall refer to the eight schools by the names of the states in which they are located except for Perkins School for the Blind, which will be designated Perkins.

TABLE I.—*Distribution by Home States of Children Currently Enrolled in the Eight Schools' Deaf-Blind Departments*

Ala.	1	Ind.	4	Miss.	3	Okla.	1
Ark.	3	Iowa	2	Nev.	1	Penn.	2
Calif.	8	Kans.	5	N. J.	4	S. Dak.	1
Colo.	2	La.	1	N. M.	3	Tex.	4
Conn.	2	Mass.	2	N. Y.	9	Va.	1
Fla.	2	Mich.	8	N. C.	1	Wash.	3
Ida.	1	Minn.	1	Ohio	1	Wash.,D.C.	1
Ill.	8					Wyo.	2

TOTAL — 87

TABLE II.—*Analysis of Population of Deaf-Blind Departments in Regard to Number, Sex, Age Range, and Residence*

School	Children	Boys	Girls	Age Range	Residential Children	Day Children	In-State Children	Out-of-state Children
Alabama	15	8	7	4–16	15	0	1	14
California	8	4	4	6–18	7	1	8	0
Illinois	8	5	3	6–18	7	1	8	0
Iowa	2	1	1	6–16	2	0	2	0
Michigan	7	2	5	6–17	5	2	7	0
New York	12	7	5	6–16	12	0	8	4
Perkins	29	13	16	5–16	28	1	2	27
Washington	6	0	6	8–16	6	0	3	3
TOTAL	87	40	47	4–18	82	5	39	48

In the deaf-blind departments the majority are visually impaired deaf children. Dr. Waterhouse has explained this fact: "A visually handicapped deaf child, even one whose sight is sufficient to cope with large type cannot be educated adequately in most programs for deaf children. Therefore a highly specialized program such as that designed for deaf-blind children is necessary and at the present time existing deaf-blind educational departments seem to be the most suitable placement."[48] (p. 15)

The terms used in Table IV are defined below:

The vibration method, devised by Sophia Alcorn, is also called the Tadoma Method.[1] It is the modern system of teaching deaf-blind children to speak and to understand speech through tactile clues given by the vibrations of

TABLE III.—*Analysis of Population of Deaf-Blind Departments in Regard to Handicaps*

School	Total Pupils	D-B	D-PB	B-PD	PB-PD	A-PB	Add. H.*
Alabama	15	1	12	1	1		2
California	8		7		1		3
Illinois	8	2	3		1	2	
Iowa	2		2				2
Michigan	7	1	4	2			2
New York	12		5	3	4		4
Perkins	29	5	19	4	1		10
Washington	6	2	3	1			2
TOTAL	87	11	55	11	8	2	

D-B = Deaf-Blind; D-PB = Deaf and Partially Blind; B-PD = Blind and Partially Deaf; PB-PD = Partially Blind and Partially Deaf; A-PB = Aphasic and Partially Blind; Add. H. = Additionally Handicapped.

*Additional handicaps reported by the various schools were in some cases definitely diagnosed and in others were only suspected. The following were listed: aphasia, ataxia, brain damage, cerebral palsy, diabetes, emotional disturbance, epilepsy, cardiac condition, mental retardation, and motor disability.

speech and movements of facial muscles. The child places his hands on the teacher's face and then on his own face as he is encouraged to imitate the vibrations and muscular movement associated with the production of speech.

Visual lipreading is the process by which a person with usable vision understands what is said by watching the lip movements and facial expressions of the one speaking.

Motokinesthetic[51] speech training involves learning to co-ordinate those muscles used for speech or facial expression and for the control of air current. Tactual stimulation is given on various parts of the pupil's face by the teacher to aid the pupil in learning the form and direction of the movements needed for speech production.

Alcorn symbols, devised by Miss Alcorn, are abstractions or simplifications of the lip positions of the vowel sounds. Basic symbols may be defined in the form of pictures or more concretely with pipe cleaner forms. This latter representation is, of course, essential for the children with no usable sight. These symbols may be useful in initially learning to produce the vowel sounds and later for quick correction or recall.

The manual method, the one-hand manual alphabet, is the best known in this country. The deaf-blind person places his hand lightly over the speaker's hand to feel the position of the fingers. For each letter of the alphabet there is a corresponding hand position. The fingers move directly from one letter to another with a slight pause between words.

Responses to questionnaires indicate that the deaf-blind children attend regular classes of the school in which the department for deaf-blind children exists whenever the deaf-blind child can so profit. In a few instances this is in academic subjects, but largely the integration with the deaf or blind is in such activities as physical education,

TABLE IV.—*Instruction in the Departments for Deaf-Blind Children*

School	Pupils per Teacher	Total Pupils	Prep. Level	Acad. Level	Methods of Instruction							
					Oral				Manual	Combined Manual & Oral	Braille	Large Print
					V.	V.L.	M.K.	A.S.				
Alabama	2–3	15	4	11	X	X		X		X	X	X
California	3–4	8	2	6	X	X	X				X	X
Illinois	2	8	3	5	X		D			X	X	X
Iowa	2	2	1	1	X		D			X	X	X
Michigan	2–3	7	2	5	X	X	X	X			X	X
New York	2	12	5	7	X	X	D	X		X	X	X
Perkins	2	29	17	12	X	X					X	X
Washington	3	6	2	4	X						X	X

V.=Vibration Method; V.L.=Visual Lipreading; M.K.=Motokinesthetic Method; D.=Motokinesthetic Method once taught, now discontinued; A.S.=Alcorn Symbols.

industrial arts, and home economics. Four schools report separate buildings for educating deaf-blind children.

Subject matter taught in the various departments includes: development of speech and language, vibration speech-reading; visual lipreading; auditory training; reading and writing of braille; the reading and writing of large print; arithmetic, social studies, spelling, and other academic subjects when and if the pupil develops communication and study skills equal to the task. The prevocational programs include woodworking, caning, weaving, knitting, crocheting, sewing, home economics, crafts, and ceramics.

Total staff members in the 8 departments for deaf-blind children vary from 2 to 37. Five schools have a head for the deaf-blind department; teaching done by this person ranges from none at all, due to administrative duties, to full-time teaching. Teachers in the departments vary from 2 to 15, with houseparents, attendants, secretaries, physical education teachers, occupational therapists, home economics teachers, and many others named on the questionnaire as playing roles of importance.

Responses to queries on educational background and training of teachers and requirements for teacher qualification reveal an effort everywhere to have trained, experienced, qualified teachers, but the teacher shortage is often a real obstacle. Three schools have undertaken the training of teachers. Alabama in an inservice program gives courses in the teaching of speech to the deaf and of speech and language to the deaf-blind along with the study of braille. Michigan offers undergraduate courses at Michigan State University in teaching the blind and the deaf and allows for supervised practice teaching of deaf-blind children. The teacher-training course at Perkins has been mentioned previously.

Socialization, After-School Care, and Integration with Deaf or Blind Pupils

In regard to socialization and care in after-school hours, the following quoted responses to the questionnaire exemplify the evident effort being made to give deaf-blind children supervision and opportunities for socialization according to need and ability:

The deaf-blind are integrated in our regular dormitory life. They take part in all activities in the residence halls. They also take part in all student organizations such as Student Body, Boy Scouts, Campfire Girls, etc....

TABLE V.—*Staff and Teacher Training**

School	Staff	Dept. Head	Does Head Teach?	Number of Teachers	Personnel from Other Departments Involved?	Teacher Training Program
Alabama	9	Yes	Yes, 100% of time	5	Yes	Yes (inservice)
California	2	No		2	Yes	No
Illinois	7	Yes	Yes, 100% of time	4	Yes	No
Iowa	2	Yes	No	1	Yes	No
Michigan	3	Yes	Yes, 65% of time	3	Yes	Yes (Undergrad. level)
New York	7	Yes	Yes, 50% of time	4	Yes	No
Perkins	37	Yes	No	15	Yes	Yes (Graduate level)
Washington	2	Yes	Yes, 100% of time	2	Yes	No

*As of January 1, 1960

Two high school girls and one elementary girl are fully integrated in regular dormitories. Two day students return home each day. ... Three children are integrated in dormitory life and in recreation. Three others have special cottage supervision and special recreation programs. . . . Five children in the preschool category are in the care of housemothers. Older academic children are integrated in houses with the blind children.

Degree of integration of deaf-blind children in dormitories or cottages of the eight schools varies with the schools' physical facilities and children's capabilities. Three schools, California, Iowa, and Perkins, have complete integration and the others integration to some extent.

Further Information

The questionnaire also includes the following information: 4 of the schools accept out-of-state pupils; 5 have a minimum age for admission, varying from 4½ years to 6 years; reasons for termination of education are, mainly, failure to profit from the program, emotional disturbance, or attainment of age 20; in 6 schools, per capita costs are financed by the state and in the remaining 2 state aid supplements school resources and endowment; the importance of evaluation, guidance, and research is recognized. Special problems listed were: the securing of qualified teachers; lack of diagnostic instruments for determination of educability; education of the multiple-handicapped child; lack of dormitory and classroom space; need for more contact with parents—especially those of the preschool child; lack of state or private facilities for children found to be uneducable or merely trainable. Plans for the future emphasize helping deaf-blind children attain their full potential. New buildings and additional staff members are hoped for as well as the upgrading of the teaching profession, the establishment of more teacher training programs, and the attainment of improved diagnostic and evaluation procedures.

Evaluation

Need for diagnostic evaluation of deaf-blind children as to educability has been increasingly recognized in the last few years. On becoming director of Perkins School for the Blind in 1951, Dr. Waterhouse, concerned with the lack of means of evaluating the deaf-blind's educational potential, began devoting time and effort to the problem. At the Conference of Educators of Deaf-Blind Children held at Perkins in April, 1953,[9] the need was emphasized. The National Study Committee at Council Bluffs in January, 1954, stated this need to be "the adaptation of psychological tests and measurements to make them applicable for use with the deaf-blind (or the development of new tests)."[30 (p. 10)] At the Workshop for Teachers of Deaf-Blind Children in June, 1955, the need for evaluation of deaf-blind children was a major issue.[4]

This resulted in Helmer R. Myklebust, Ed.D., of Northwestern University being invited to Perkins to undertake diagnostic procedures with deaf-blind children. During five visits between 1955 and 1958, the knowledge and guidance of Dr. Myklebust were of inestimable value to the Perkins staff and to the cause of evaluation in general. Dr. Myklebust has described his diagnostic approach in his book *The Deaf-Blind Child*.[29]

In September, 1958, Perkins began an independent evaluation program based on Dr. Myklebust's suggestions and guided by Carl Davis, head, Department of Psychology and Guidance. Evaluative services are offered by Perkins. The Perkins evaluation "team" has studied children at the Industrial Home for the Blind in New York, the Children's Rehabilitation Unit of the University of Kansas Medical Center at Kansas City,[32, 48] the California School for the Blind, and Washington State School for the Blind. On these trips, 33 children have been evaluated. At Perkins the children enrolled in the Department for Deaf-Blind Children are observed by this evaluation team. From time to time other children in need of diagnostic study are brought to the school. Recently a young deaf-blind child was brought from Switzerland for evaluation.

We remind our readers of the other organized evaluative study of deaf-blind children mentioned in our discussion of activities of the American Foundation for the Blind. We refer to the diagnostic clinic for the observation of multiple-handicapped children at the Center for the Development of Blind Children at Syracuse University, a clinic to which the American Foundation for the Blind refers deaf-blind children.[34]

According to present-day thinking, evaluation of a deaf-blind child involves many avenues of approach: History-taking, including prenatal and birth history, history of illness, genetic development, emotional adjustment, auditory behavior, language behavior, and educational history; study of residual sensory capacities, including a differential diagnosis as to type of auditory disorder, *i.e.*, whether due to peripheral deafness, psychogenic deafness, aphasia, or mental deficiency;[28] study of the neurological aspects; psychological examination. In the last-named, Dr. Myklebust includes the examination of mental and motor capacity and of social maturity, and the evaluation of emotional adjustment.[29]

Because of limited experience with deaf-blind children and the difficult factors involved, psychologists and members of the medical profession are frequently baffled in the attempt to evaluate these children. Factors such as communication problems, which prevent the examiner from "reaching" the child and the child from giving evidence of his abilities to the examiner, and retardation due to environmental deprivations may lead to a false diagnosis of mental deficiency. On the other hand, some deaf-blind children are mentally defective, and a contrary diagnosis and subsequent placement in a department for the education of deaf-blind children lead to waste of money and the time of trained teachers. The importance of correct

evaluation cannot be over-stressed and the difficulties involved and the need for research must be admitted.[41]

Research

At Iowa in 1954, the National Study Committee listed the following areas for research in regard to the deaf-blind:

1. The affect of deaf-blindness upon the personality structure. *a*) To what extent is mental illness or retardation more prevalent in this group compared to a so-called normal group? *b*) Are regressive characteristics more common at the outset of deaf-blindness in this disabled group when compared to other types of disability? *c*) What are the most prevalent types of adjustment mechanisms employed by the deaf-blind upon onset of the disability? *d*) What is the relationship between maladjusted and deaf-blind children and the degree of parental acceptance? *e*) Is rigidity more common among the deaf-blind than among the deaf or the blind? *f*) Is there a different personality pattern in the congenitally deaf-blind than in the adventitiously deaf-blind?
2. The adaptation of psychological tests and measurements to make them applicable for use with the deaf-blind (or the development of new tests).
3. Counseling techniques, psychotherapy, and mental hygiene for the deaf-blind.
4. Vocational training and job adjustment.
5. The social psychology of deaf-blindness.
6. Educational and instructional methods with the deaf-blind.
7. Sensory aids and travel orientation.[30] (p. 9-11)

Research on many of these problems is in progress. The American Foundation for the Blind and the Industrial Home for the Blind have made definite progress in research with the adult deaf-blind, especially in communication,[10, 20 (II), 50] vocational training and job adjustment,[3, 20(V)] and the use of psychological tests.[20(IV)] Schools with departments for deaf-blind children are giving increasing attention to the aspects of research concerned with children and youth.

In September, 1956, a research worker was appointed to the staff of the Department for Deaf-Blind Children at Perkins. Much of the research has since been concerned with the exploratory use of psychological tests with deaf-blind children,[38] still in an experimental stage. No one test is satisfactory with all deaf-blind children; items from various tests must be used in the evaluative attempt. Qualitative observations rather than quantitative results are emphasized and the child's test performance is considered in the light of his total syndrome, with the examiner's observation and experience with other deaf-blind children as a frame of reference.

It is hoped continued use of the tests may reveal correlation between mental capacity and etiology of handicap, age at onset of handicap, and the other variables characterizing the population and precluding expectation of established norms for the deaf-blind. The prognostic value of the tests is being observed through their use over a period of time in an effort to determine their accuracy in estimating mental ability. Because of the dearth of tests appropriate for use with the totally deaf-blind, research is needed in the use of existent tests, the adaptation of others, and the devising of new ones.

In many other areas the need for research has been recognized and work commenced. Genetic development and social maturity are extremely significant, especially as to the very young deaf-blind child to whom psychological tests cannot be given. Other studies, to name only a few, are of parent-child relationships and parent counseling, auditory disorders, language behavior, methods of instruction and curriculum development, the medical aspects of deafness and blindness, and the education of deaf-blind children in other parts of the world.

Rehabilitation

The aim here is not to discuss rehabilitation as it applies to the adult deaf-blind but only to touch upon it to the degree that the future rehabilitation of deaf-blind children may be the concern of educators. Dr. Waterhouse has previously dealt satisfactorily with this;[42] the following material consists of our additional thought.

Sound educational programs in the eight departments for deaf-blind children constitute a foundation for the rehabilitation program many deaf-blind persons enter at the end of their school years. The roots of rehabilitation reach far down into the education of the handicapped. "As educators look forward with hope to their pupils' futures, rehabilitation workers ask what kind of material they may expect to welcome as clients."[42] (p. 15)

Diversity of handicaps, environmental differences, and variation in inherent potentials lead to corresponding diversity in skills and personalities, but basically the educational approach to deaf-blind children irrespective of handicap should have the ultimate aim of teaching, guiding, and preparing them so they will be as ready as possible intellectually and emotionally for the after-school years. In these years some of the children may not need rehabilitation programs, some may not be able to profit, and others will need them in varying degrees.

Preparation for this readiness cannot begin too soon. Ideally, it starts with early diagnosis of deaf-blindness, followed immediately by parent counseling. Too often a lack in these two has led to neglect or unconstructive handling of the child, with knowledge of and the meeting of his needs coming too late to permit his developing to the limit of his innate maximum potential.

During the school years the teachers, aided by other professional workers, are responsible for helping the child adjust to problems, develop habits of self-care and independence, acquire communication and language skills, be as mobile as possible, have right work attitudes, live as normally and creatively as possible, and develop abilities and technics to be put later to wider use in training

for employment. The degree that vocational training is stressed may vary, influenced by the thought of educators, school facilities, abilities and personalities of pupils, and types of rehabilitation programs pupils may enter on leaving school. A desirable philosophy regarding the actual vocational education of the deaf-blind student seems to us to be that expressed by Boyce Williams, consultant, U.S. Office of Vocational Rehabilitation, concerning the deaf: Vocational teachers should be "developers of good attitudes and work habits" and should have "realization and acceptance of the fact that their subject matter is not an end in itself" but "is a means to the greater end of teaching boys and girls to be better, more effective, men and women."[49 (p. 154)]

When the child no longer benefits from the educational program and if he is believed to have potential for employment but to be in need of rehabilitation, he should be enrolled in a rehabilitation program. All pertinent information concerning him should be given to the rehabilitation worker, with whom the teacher should collaborate, if possible, in the beginning stages of this new step. The planning of a program for the deaf-blind adult is of course the responsibility of the rehabilitation worker, but this task will be far easier if the teacher has helped his pupil acquire attitudes and insights that may compensate for his handicaps, augment his abilities, and help him attain what Helen Keller has described as "the dignity of self-support and the joy of usefulness."[22, 20 (1, p. 175)]

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The December Issue

The December issue of *Rehabilitation Literature* will feature as its Article of the Month "Housing Needs of the Aged; With a Guide to Functional Planning for the Elderly and Handicapped." The author is Alexander Kira, assistant director, Cornell University Housing Research Center, Ithaca, N.Y. This issue will also contain the special report "The Problem of Disability Arising from Neglected Trauma," by Dr. J. Francis Silva, Orthopedic Department, General Hospital, Ceylon, India.

Clinical Management of Behavior Disorders in Children

By Harry Bakwin, M.D.

and

Ruth Morris Bakwin, M.D.

Published by W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. 1960. 597 p. figs., tabs. (2d ed.) $11.00.

About the Authors . . .

Dr. Harry Bakwin received his M.D. degree from Columbia University (1917); Dr. Ruth M. Bakwin, his wife, earned an M.D. degree at Cornell University (1923). He is professor of clinical pediatrics, New York University; visiting physician, Bellevue Hospital; and attending pediatrician, University Hospital, New York City. She is associate professor of clinical pediatrics, New York University; visiting physician, Bellevue Hospital; and director emeritus, department of pediatrics, New York Infirmary.

About the Reviewer . . .

Dr. Kanner received his M.D. degree at the University of Berlin, Germany, in 1921. He came to the United States in 1924 as senior assistant physician, Yankton (S. Dak.) State Hospital. From 1928 to 1930 he was a Commonwealth Fund fellow in psychiatry at Johns Hopkins University and has since been affiliated with the University and Johns Hopkins Hospital in the fields of psychiatry and pediatrics. Dr. Kanner is now a lecturer in McCoy College in the University's department of adult education, professor emeritus of the University, and honorary consultant in child psychiatry for the Hospital. He has just completed a year as Distinguished Visiting Professor of Psychiatry, University of Minnesota. In 1960 he received the first annual award from the National Organization for Mentally Ill Children.

Reviewed by Leo Kanner, M.D.

IT IS GRATIFYING to know that the popularity of the first edition and the progress in child psychiatry have prompted the authors to revise and bring up to date their—here I am groping for the right word: textbook? compendium? handbook? Perhaps it would be best to drop the customary designations and characterize the volume as a comprehensive, informative, and readable review of a richly ramified and constantly expanding area of knowledge and endeavor. There has been of late no dearth of books on the behavior problems of children. Some of them are excellent guideposts to principles and practice. Others confuse rather than help those entrusted with the care of children because they are based on premises derived from doctrinaire theories and presented as a take-it-or-leave-it sort of indoctrination. The authors of this book make their stand very clear. They state in the preface: "In this edition, as in the previous one, we have sought to distil, from the large amount of material published, the observations in child psychiatry which are well documented and which have been found helpful in understanding and treating healthy as well as problem children." This determination has been adhered to from the first page to the last.

It should be a source of particular satisfaction that so detailed a discussion of behavior disorders comes from two pediatricians. The time is not too distant in the past when the newly formed child guidance and mental hygiene clinics, introducing the novel and helpful idea of the interdisciplinary team, promptly restricted the concept and its application to three disciplines only: psychiatry, psychology, and social work. Pediatricians and educators were kept away from the clinic doors and, if at all considered, were looked upon at best as recipients of

ex-cathedra advice and admonition emanating from the team. It came to a point when, in 1931, Joseph Brennemann, the then dean of pediatrics in the United States, issued to his colleagues in their official journal a warning entitled "The Menace of Psychiatry." Around that time psychiatric service was established in the main stream of a pediatric hospital, and a psychiatric-pediatric alliance was formed on the basis of mutual respect and collaboration. Shortly thereafter, Brennemann could declare that what had seemed to be a menace had thus been changed to a promise.

The Bakwins took an active interest in the rapid strides made in the field of child psychiatry during the past few decades. They kept in touch with the active contributors, scanned the literature, tried to apply that which they found useful in their clinical work, and in many articles one or the other or both undertook the important task of bringing current findings and insights to their fellow pediatricians in periodicals easily accessible to child specialists. In 1942, they were able to offer a summing up of their efforts in the form of a book *Psychologic Care During Infancy and Childhood* (Appleton-Century Company). Keeping out of polemics, they declared: "In a field where so much is controversial it is important that the physician remain as nearly as possible within the realm of common sense and experience."

When the first edition of *Clinical Management* appeared in 1953, the authors again emphasized their loyalty to empiricism and objectivity: "Concepts and seeming facts have been critically evaluated in the light of experience in general pediatric practice and of close association with child psychiatrists and their writings."

The second edition being reviewed here does not differ essentially from its predecessor. There are still the same sections or "parts": growth and development; psychologic care; care of the physically ill and handicapped child; etiologic factors; diagnosis and treatment; problems related to mental functioning; developmental abnormalities; problems related to emotional development; problems of habit and training; organic disturbances with a large psychic component; antisocial behavior; specific syndromes.

Within the framework of these parts, some of the chapters have been rearranged by combining several into one or assigning a special chapter to a topic previously included with related issues under a common heading. The introduction of a few new chapters or subheadings indicates either new observations since the publication of the first edition (*e.g.*, circumscribed interest patterns; manic-depressive disease), increased emphasis (*e.g.*, tranquilizers), or the authors' change of attitude (*e.g.*, a chapter on hysteria, which was not even mentioned in the index of the first edition). The organization of such vast and variegated material is beset by major difficulties and, on the whole, the authors have done an excellent job, avoiding too much overlapping or repetition. One might, however, suggest a few changes for the next edition. It is somewhat bewildering to find shyness linked in one chapter with excessive anger, aggression, negativism, and cruelty. It is equally puzzling to find daydreaming and imaginary playmates discussed together with thumb-sucking, rhythmic motor habits, nail-biting, nose-picking, lip-sucking, and teeth-grinding under the caption "Everyday Habits." A more congruous relocation would seem to be in order. One might also wish that the authors emancipate themselves from the persistent semantic error which uses "mental" as synonymous with "intellectual." Needless to say that "the emotions" are no less a feature of "mental functioning" than matters of cognition.

I am sure that the authors do not wish to be considered as child psychiatrists. As psychiatrically oriented and informed pediatricians, they have tried successfully to strip their presentation of much of the abstruse speculation and the gobbledygook that have been paraded in some quarters as the ultimate wisdom. The references have been selected carefully. The text refrains equally from glib generalizations and from obsessive detail.

The Bakwins deserve the gratitude of child psychiatrists for transmitting to people in the medical and ancillary professions the gist of their specialty in a manner that cannot help but command respect for the enormous advances made in the past few decades. Child psychiatrists could not have found better spokesmen outside the ranks of their own discipline.

Other Books Reviewed

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Baby Talk

By: Morris Val Jones, Ph.D.

1960. 96 p. illus. Charles C Thomas, Publ., 301-327 E. Lawrence Ave., Springfield, Ill. $4.50.

DOES MY CHILD have a speech problem? Should I seek professional help for him? What causes "baby talk"? What can I do at home to improve his speech? In his many years of working with speech-handicapped children and counseling with their parents, Dr. Jones has doubtless encountered these and similar questions innumerable times. This book, written especially for parents, should meet the need for a guide in helping their children overcome nonorganic articulatory errors. Professional workers should also find it extremely useful for counseling purposes. Dr. Jones explains how parents may recognize

speech problems and locate speech correction resources in the community. Other chapters suggest ways for stimulating speech and language development in the home and for eliminating physical and environmental factors contributing to speech problems. A series of tests for parents (more than 100 questions to be answered by "yes" or "no") is interspersed throughout the book; the tests can aid in discovering factors responsible for the child's failure to develop correct speech. Appropriate answers are given in the appendix so that parents' experience can be checked against professional opinions. Dr. Jones was formerly associate professor of speech at Illinois State Normal University; he now is a specialist in speech and hearing, School for Cerebral Palsied Children, San Francisco.

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A Demonstration and Research Study of the Vocational Rehabilitation of the Physically Rehabilitated Hemiplegic in a Workshop Setting; Final Report of O.V.R. Special Project 195

By: **James A. Howard,** Ph.D., Principal Investigator (with the Research Staff of Community Rehabilitation Industries, Inc., Frank J. Kirkner, Project Director)

1960. (132) p. tabs. Mimeo. Looseleaf. Paperbound. *(O.V.R. Special Project 195 [195C, 195C1])* Community Rehabilitation Industries, Inc., 1438 E. Anaheim Blvd., Long Beach 13, Calif.

THE FINAL REPORT of a pioneer project in vocational rehabilitation of hemiplegics, sponsored by the U.S. Office of Vocational Rehabilitation, the Heart Association of Long Beach, and Community Rehabilitation Industries, a transitional workshop for training and placement of the physically disabled, contains a description of the study technics, with a mass of data on personal characteristics of the subjects. Direct work benefits did occur in almost one-third of the 47 persons accepted for intensive vocational exploration and training; the findings imply that the vocational potential of hemiplegics is greater than has been believed. In addition to the report itself, the publication contains papers published in professional journals (including the research report that appeared in *Rehab. Lit.,* Feb., 1960, p. 58-60) and a manual describing Community Rehabilitation Industries' services offered to the physically handicapped from the time of the client's original application to final disposition of his case.

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Financing and Operating Rehabilitation Centers and Facilities; A Study of Ten Rehabilitation Centers

By: **Basil J. F. Mott, Herman W. Gruber, Ronald R. Kovener,** and **Max A. Mergle**

1960. 154 p. figs., tabs., charts. Paperbound. National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago 12, Ill. Free distribution.

FOR THOSE CONCERNED with the administration of rehabilitation centers, this third, and last, in a series of publications financed by grants from the Easter Seal Research Foundation and the U.S. Office of Vocational Rehabilitation presents findings and conclusions from an intensive study of 10 comprehensive rehabilitation centers. The first part of the report offers a general discussion of the principal characteristics of the centers studied, a summary of the findings and conclusions, and the authors' interpretation of them. The remaining four parts are concerned with a detailed and technical presentation of findings and conclusions in regard to financing, staffing, service to patients, and output and input. The appendix contains technical notes and 50 statistical tables of basic data. There has been no attempt to evaluate the quality of rehabilitation operations in the centers studied; rather, operating problems are defined in such a way that the information can be used as a yardstick in evaluating operational efficiency in a center. For a review of the two earlier studies in the series, see *Rehab. Lit.,* Sept., 1960, p. 280.

779

A Good Fight; The Story of F.D.R.'s Conquest of Polio

By: **Jean Gould**

1960. 308 p. Dodd, Mead & Co., 432 Park Ave. South, New York 16, N.Y. $4.00.

FROM SUCH SOURCES as Eleanor and James Roosevelt, Dr. Robert Bennett, Medical Director of Georgia Warm Springs Foundation, Basil O'Connor, President of the National Foundation, and a host of people who knew F.D.R. intimately, Miss Gould has reconstructed the story of the late President's gallant victory over poliomyelitis. Here, in some detail, is the account of his life, political career, his discovery of Warm Springs, and lifelong devotion to conquest of the disease. Much more is told in this biography, than in Turnley Walker's earlier story, of the serious physical problems Roosevelt had to overcome, the mechanical aids contrived to enable him to carry on an active role as Governor of New York and later as President of the United States during times of great crisis.

780

Guide to Jobs for the Mentally Retarded; Handbook

By: **American Institute for Research** (Richard O. Peterson, Director, Technical Training Program, and Edna M. Jones)

1960. 82 p. forms. Planographed. Spiral binding. American Institute for Research, 410 Amberson Ave., Pittsburgh 32, Pa. A limited number of the handbooks (with accompanying kit of 131 Job Requirements Profiles) are available at $5.00 a set.

THE HANDBOOK and a series of 131 Job Requirements Profile forms comprise a system for integrating and using job information appropriate for the retarded individual. The procedures described in the handbook can be used in four quite different functions of the counselor —client selection and evaluation, training, job identification, and placement. The flexibility of the system provides for tailoring the training and counseling program of the workshop to fit the trainee for competitive employment in a specific community. Appendixes contain a complete list of the Job Requirements Profiles arranged by major groupings, an index to employing organizations relating to the Profiles, and a bibliography of selected references on the establishment and operation of vocational training and placement programs for the mentally retarded.

781

Hearing and Deafness

Edited by: **Hallowell Davis,** M.D. (Coeditor for the revised edition, S. Richard Silverman, Ph.D.)

1960. 573 p. illus., figs., graphs. (*Rev. ed.*) Holt, Rinehart and Winston, Inc., 383 Madison Ave., New York 17, N.Y. $7.95.

SINCE ITS ORIGINAL publication in 1947, this comprehensive textbook on audiology has been used extensively as an introductory source of information for students. Now fully revised and brought up to date by 15 leading specialists in the field, it covers the physics and psychology of hearing, physiology of the ear, medical and surgical treatment of hearing loss, auditory tests and hearing aids, the technics of rehabilitation, and the management of educational, social, and economic problems of the deaf and hard of hearing. A variety of aids for the student and therapist, physician and audiologist, is contained in the appendix—word- and sentence-lists used as tests of hearing, a brief glossary of auditory terms, and subject and author indexes. The book is highly recommended by the president of the American Hearing Society to all those seeking correct answers on hearing and deafness. Summaries of all chapters' contents are given in Part I to aid the reader in identifying particular portions of the book that may be of special concern.

782

Human Tortoises; A Spastic's Story

By: **Peter Godwin**

1960. 143 p. Max Parrish and Co., Ltd., 55 Queen Anne St., London, W.1, England. 12s 6d, net.

ATHETOSIS in not too severe a form has plagued Mr. Godwin since childhood; the trials and tribulations of his fight to achieve as nearly normal a life as possible apparently have resulted in frustration and much bitterness. He is especially articulate in condemning some of the medical advice he received and the ineffective aid offered by government officials and agencies under England's system of socialized medicine. The book is a plea on behalf of all cerebral palsied persons for better public understanding of their problems. The education and financial independence Mr. Godwin has won are due to his tenacity in fighting for what he believes in so strongly.

783

The Incredible Mr. Kavanagh

By: **Donald McCormick**

1960. 205 p. illus. Putnam and Co., 42 Great Russell St., London, W.C. 1, England. 21s.

EXPERT HORSEMAN, active in field sports, world traveler, yachtsman, amateur photographer, landlord of an Irish estate, Member of Parliament and later Privy Councillor of Ireland, a devoted husband and the father of six children, Arthur Kavanagh lived a full life in spite of severe physical handicaps. Born without arms or legs at a time when the manufacture of artificial limbs was in its infancy (1831), he surmounted his difficulties through versatility. That he was able to overcome his disability in so amazing a way was due partly to the indomitable spirit of his mother, to the advice and care of a perceptive, devoted physician, and to the acceptance of his family and community. The motivation, however, lay in his own desire to live a normal man's life.

784

New Hope for Stroke Victims

By: **Robert A. Kuhn, M.D.**

1960. 206 p. figs. Appleton-Century-Crofts, Inc., 35 W. 32nd St., New York 1, N.Y. $4.00.

AN AUTHORITY in the field of neurology and neurological surgery, Dr. Kuhn describes in terms the ordinary person can understand the advances in medicine and surgery that offer encouragement to the patient and his family. Various types of "strokes," their causes and management, and the special technics now used in prevention and cure are discussed; a chapter is devoted to case histories of patients successfully treated. A question-and-answer section offers information on causes, symptoms,

diagnostic technics, and preventive measures. The seven-page bibliography of selected references is annotated.

785

Obstetrics (from the original text of Joseph B. De Lee, M.D.)

By: **J. P. Greenhill, M.D.**

1960. 1098 p. illus. *(12th ed.)* W. B. Saunders Co., W. Washington Sq., Philadelphia 5, Pa. $17.00.

COMPLETELY rewritten and brought up to date with the addition of new chapters and 162 new illustrations, this well-known textbook first published in 1913 offers a comprehensive review of the field of obstetrics. Part II, covering the pathology of pregnancy, labor, and the puerperium, contains chapters of special interest: Fetal erythroblastosis and the Rh and other blood factors, Israel Davidsohn *(Ch. 49)*.—Clinical aspects of the newborn *(Ch. 66)*.—Pathology of the newborn, James B. Arey *(Ch. 67)*.—Obstetric aspects of fetal malformations *(Ch. 68)*.—Perinatal brain injury with special reference to cerebral palsy, Meyer A. Perlstein *(Ch. 69)*.

Dr. Greenhill was aided in the preparation of the book by many authorities in obstetrics and related branches of medicine.

786

On the Shoulders of Giants; The Bea Wright Story

By: **Eleanor Chappell**; with forewords by Basil O'Connor and Helen Hayes

1960. 105 p. Chilton Co., Book Division, 56th and Chestnut Sts., Philadelphia 39, Pa. $2.75.

BEA WRIGHT'S work as publicity director for the National Foundation in Detroit brought her into direct contact with stricken patients when poliomyelitis in epidemic proportion hit that city. She herself became ill from the disease she was working so tirelessly to overcome. In 1953 her doctor told her that she would never walk again but her belief that faith was courage and "power in action" proved him wrong. After a year in the hospital and six years in a wheel chair and on crutches, during which time she was working as National Assistant Director of Women's Activities for the National Foundation in New York, Bea Wright achieved the impossible; she has now been walking without crutches for three years. The forces that aided her recovery and the dramatic events of the Salk vaccine trials, now history, are skillfully interwoven by her friend and biographer. The story has an almost fictional conclusion in her happy second marriage. Miss Hayes, in her foreword, calls Bea Wright's story a "modern miracle," and her achievement one that will bring fresh hope and inspiration to the disabled.

787

The Oregon Study of Rehabilitation of Mental Hospital Patients

Supported by: **Oregon State Hospital, State Board of Health, State Public Welfare Commission,** and the **Oregon Division of Vocational Rehabilitation.** John James, Research Director; C. F. Feike, Chairman, Project Executive Committee

1960. 2 vols. in 3 bindings. tabs., forms. Issued by the Oregon Division of Vocational Rehabilitation, 1178 Chemeketa St., N.E., Salem, Ore.

IN THIS detailed report of a three-year research and demonstration project to determine the effectiveness of a comprehensive rehabilitation program for mental hospital patients, Volume I contains the research director's summarization of the purpose, design, rehabilitation activities, and role of the co-operating state agencies. Part I and II of Vol. II contain, respectively, 14 scientific working papers by research staff members on rehabilitation processes related to conditions of the study and 17 papers by members of agency staffs participating in the project. Findings showed that the operations of the project had greater impact on intra- and interagency awareness of their own abilities and limitations for providing services than on patients' posthospital adjustment. The experience and results achieved provide much insight on the adjustment problems of released mental patients and the wide range of variables affecting successful rehabilitation. The principal problems encountered suggested the recommendations for further scientific social psychiatric research.

788

The Other Child, the Brain-Injured Child; A Book for Parents and Laymen

By: **Richard S. Lewis, Alfred A. Strauss, M.D.,** and **Laura E. Lehtinen, M.A.**

1960. 148 p. *(2d revised and enlarged ed.)* Grune & Stratton, 381 Fourth Ave., New York 16, N.Y. $3.75. (Available in Great Britain from Grune & Stratton, 15/16 Queen St., Mayfair, London, W. 1, England)

THE FIRST EDITION of this book, published in 1951, was well received by professional persons and parents alike. The result of collaboration among Dr. Strauss and Miss Lehtinen and Mr. Lewis, a professional writer, was a book written in nontechnical terms but offering authoritative information based on Dr. Strauss's and Miss Lehtinen's work. Both are well known for the research conducted at the Cove Schools, founded in 1947 (Racine, Wis.) and 1950 (Evanston, Ill.) by Dr. Strauss. Mr. Lewis's interest in the brain-injured child stems from personal knowledge of the condition, as parent of a child

so handicapped. New material in this second edition, in addition to that contributed by Miss Lehtinen, a psychologist, was dictated to Mr. Lewis shortly before Dr. Strauss's death in 1957. Parents will find the simple, straightforward explanations of brain injury and its effect on behavioral patterns and perceptual and conceptual functions of the brain of immense help in understanding the problems of their "other" child. Practical suggestions for the successful management and education of these children in the home and at school are included. This new edition, nearly double the size of the original, discusses developments in this special field since 1951.

789

School Library Services for Deaf Children

By: **Patricia Blair Cory; with a foreword by Clarence D. O'Connor**

1960. 142 p. illus. Paperbound. *(Lexington School for the Deaf Education Ser., Book II)* Alexander Graham Bell Assn. for the Deaf, Volta Bureau, 1537 35th St., N.W., Washington 7, D.C. $3.20, postpaid.

THE MONOGRAPH series planned by the Lexington School for the Deaf will contain outlines of the goals set for pupils at the School and descriptions of activities, technics, and devices found useful in achieving these goals. This second book of the series deals with much more than the mere mechanics of library management. Mrs. Cory, librarian and visual education director at the School since 1951, presents the realistic philosophy underlying objectives of a library program in schools for the deaf. Her sound and practical suggestions for getting the most out of library activities when working with deaf children should be helpful to administrators and teachers. Although brief sections are included on administration and organization of the library, the main emphasis is on services to meet the needs of deaf children and on the selection of suitable library materials for their use. Programs for children of all ages, from nursery school through the teenage years, are discussed.

790

Seminar on Rehabilitation of the Physically Handicapped for Participants from Latin American Countries, Copenhagen . . . 21 June to 24 July, 1959 . . .

By: **United Nations**

1960. 108 p. tabs. Paperbound. *(ST/TAO/Ser. C/41)* United Nations, New York, N.Y.

THE FIVE-WEEK Seminar, organized by the United Nations and the government of Denmark, in co-operation with the International Labour Organization, World Health Organization, World Veterans Federation, and International Society for the Welfare of Cripples, included lectures and demonstrations of modern methods and technics of rehabilitation applicable to conditions in Central and South America. Promotion of regional co-operation among Latin American countries and problems of planning and administering rehabilitation services were also considered. The report contains synopses of lectures and group discussions on the medical, social, vocational, and educational aspects of the comprehensive rehabilitation program. Dr. Henry H. Kessler spoke on the scope and content of a modern rehabilitation program and participated as a panel member in a discussion of the role and place of various specialists on the rehabilitation team. Recruitment and training of personnel and the education of public opinion were subjects covered by Eugene J. Taylor. Donald V. Wilson of the International Society for the Welfare of Cripples reviewed educational aspects of rehabilitation. Eighteen conclusions, intended as a general guide to the development of services in Latin America, were adopted by the participants and appear in the report.

791

Social Security Handbook on Old-Age, Survivors, and Disability Insurance

By: **Bureau of Old-Age and Survivors Insurance, U.S. Social Security Administration**

1960. 261 p. tabs. Paperbound. U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C. 75¢.

THIS *Handbook,* covering Title II of the Social Security Act, as amended through 1959, provides a detailed explanation of provisions of the program, how it operates, who is entitled to benefits, and how they may be obtained. Disability benefits and other services provided under the Act, such as state programs for crippled children and workmen's compensation, are discussed. For convenient reference, the book is indexed for locating specific sections dealing with a particular subject.

Also available, as a companion volume, is the 1960 edition of *Basic Readings in Social Security,* a bibliography of some 1,640 references of which 1,000 are new or revised. A guide to significant books, pamphlets, articles, and periodical sources on the Act and the programs administered under it, the book also contains references to programs closely related to social security. It may be ordered from the U.S. Superintendent of Documents at $1.00 a copy, paperbound.

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Wheel Chair Kitchens

Anne E. Mahler

THE PARAPLEGIC woman, trying to carry out household duties in an ordinary kitchen, undergoes many difficulties in both comfort and convenience. The working counters are too high. The overhead shelves are difficult, sometimes impossible, to reach from her sitting position. The storage space for canned goods, staples, and cooking utensils is inconvenient for seeing and grasping. The back burners on standard counter level stoves are dangerous and inaccessible.

This report was prepared by Miss Mahler earlier this year while still an undergraduate student at the University of Illinois. She is presently employed by the Motor Vehicle Casualty Company, Elmhurst, Ill. For more detailed information concerning the research project, its methodology, and findings, the reader is referred to Space and Design Requirements for Wheelchair Kitchens, *by Helen E. McCullough and Mary B. Farnham (see Rehab. Lit., #827, this issue).*

These problems were among those encountered by Miss Helen E. McCullough, associate professor of home economics, and Mrs. Mary B. Farnham, assistant in the Home Economics Department, of the University of Illinois. In their housing research work Miss McCullough and Mrs. Farnham sought practicable new kitchen arrangements that allowed ample space for storage and room for ease of wheel chair manipulation. Guided by the grievances and suggestions from paraplegic women who worked in ordinary kitchens, these two women set about to discover what changes should be made to meet the paraplegic's special needs.

The measurements of 26 women confined to wheel chairs were taken to determine what they could reach and how well they were able to manipulate the standard kitchen equipment—sinks, refrigerators, ranges, clothes washers and driers. From these findings several different kitchen units were set up, each specially designed for safety and economy in lifting, bending, and reaching. These new designs made the food and utensils much more accessible for the homemaker with a physical disability.

To test the effectiveness of the new designs several of the paraplegic women assisting in the project prepared meals for four in the special kitchens.

Three types of kitchen floor plans were tested: the U-shape, the L-shape, and the "corridor" design, which essentially is an aisle with counter space and appliances on either side. This last type proved most satisfactory because it had none of the difficult-to-reach corners that the other two types had.

An important feature recommended for appliances is the side-hinged door. In contrast, the drop-hinged door, commonly used for ovens, clothes driers, and freezing units of refrigerators, means that the wheel chair person cannot get close enough to these appliances for adequate work movements. The drop-hinged door imposes an extra 12 to 20 inches between the individual and the appliance proper. The side-hinged door, however, enables the individual to move close to the appliance for easier, more efficient work. It is not only desirable to have appliance doors side-hinged, but they should be front-loading also. Washing machines and dishwashers are frequently loaded from the top. Such an arrangement is impossible for many wheel chair persons to operate.

The ideal counter height for the paraplegic woman is between 30 and 31 inches for the sink and range, and about 27 inches for the mix center and ironing boards. The standard 36-inch counter height in ordinary kitchens would be a substantial handicap for the paraplegic.

Shallow cupboards, no more than 12 inches deep nor 60 inches high, are recommended for people confined to wheel chairs. In general, drawer storage is preferable to shelves in base cabinets. Canned goods are ideally stored in pull-out drawers with tilted shelves. This device facilitates easy viewing and grasping. Shallow baking pans and trays can be "filed" in drop-down bins that operate according to the law of gravity. This feature is especially good for the individual with limited muscular ability. Another easy-to-use storage feature is the "Lazy Susan." Each shelf, however, must operate independently of the others for less effort in movement.

The electric mixer is placed on a special low shelf, which swings out and up for use. Such an arrangement enables the wheel chair person to work more closely to the mixer than if it were located on the top of the counter.

The range was one of the more complicated areas to improve. Open space is needed below the burner units so that the individual can sit close enough to see what is being cooked. This, however, means separation of the

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Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

794

The Management of the Spinal Paraplegic Child

By: L. Guttmann, C.B.E., M.D., M.R.C.P.

In: *Mother and Child.* Aug., 1960. 31:5:108-113.

THE PRESENT PAPER deals with management of a group of patients aged 3 to 15 years with injured or diseased spinal cords treated at the National Spinal Injuries Centre, Stoke Mandeville Hospital. Paraplegia or quadriplegia was caused by injuries, transverse myelitis, poliomyelitis, congenital abnormalities, haemangioma, tumour, and tuberculosis of the spine. Injuries were mainly due to road accidents, some to sport (*e.g.*, shooting) and to bathing, diving, or falling accidents. Level of damage varied from midcervical to the cauda equina. Rehabilitation of these children embraces varied medical and social aspects; paramount are education and resettlement. Parents and educators must be on the management team.

Management in the early stage of paraplegia

Management of the spine. This applies particularly in traumatic lesions. If x-ray films show fracture or fracture dislocation of the spine, we use postural reduction with pillows or sorbo packs (described elsewhere) for vertebral alignment. Most fracture dislocations, stable or unstable, can be satisfactorily consolidated. With nontraumatic paraplegia, the children should in the early stages be placed on sorbo packs in hyperextension and turned from side to side two-hourly, night and day. Pressure sores and complications will be prevented. For rapid healing of sores present, the patient should be placed in a prone position between the packs.

Correct positioning of paralysed muscles is essential to avoid contractures. Permanent positioning must be avoided and recumbency limited as to time to minimize osteoporosis and resulting fractures. Pillows under the knees cause adduction contractures of the legs and flexion contractures of knees and hips. Contractures of the iliopsoas result in hyperlordosis. Feet and toes are kept in dorsiflexion to avoid drop foot and contracture of the toes, which prevent standing and walking. In cases of midcervical cord lesions, permanent flexion of the forearm must be avoided, which results from the unrestrained overaction of normal biceps over paralysed triceps. Existing disability in cervical patients is greatly increased by flexion contracture of the elbow joint. The best method, aside from positioning, of preventing contractures and promoting good blood circulation is regular passive movements of all joints of paralysed limbs, several times daily, right after onset of paraplegia.

Bladder and bowels. Suprapubic cystostomy in initial management of the paralysed bladder is today generally condemned. Two routine procedures are intermittent catheterization by a medical officer familiar with the nontouch technic and indwelling catheterization with the Gibbon's polythene catheter. The first and preferred method keeps the bladder sterile for several weeks and encourages development of bladder automatism, which may occur within 10 to 14 days. Habit training for voiding at intervals may then be started. Early circumcision is sometimes necessary.

While in the initial stages, manual evacuation of the bowels, with or without enema, is necessary, individual habit training is started as soon as possible.

Management in later stages

The upright position should be established as soon as possible. Balancing exercises before a mirror in the sitting position are done at first to develop a new visually guided scheme of postural control. Later standing and walking exercises are added. Gaits used are the four-point, swing-to, and the swing-through. The sooner a child stands the better his physical development and growth.

The children, especially the older, are taught with self-care and independence exercises to dress and to transfer with or without assistance from wheel chair to bed and vice versa.

Value of sport

Sport has a tremendous effect on developing an active mind and competitive spirit. Swimming is the favourite for those between 3 and 6 years. Results in these children show at what an early age the adjustment forces in the central nervous system can be developed and mobilized to compensate for loss of motor function and postural sensibility of large parts of the body. Archery has proved ideal for paralysed children aged 7 and over. It is excellent for developing the strength of back and arm muscles and arouses the competitive spirit. An emotionally unstable child with a complete transverse lesion at T.2 incurred at age 7 improved gradually psychologically. Today he is a keen swimmer and competent archer and attends regular school from his home. His physical development at 14

years, 8 months is normal, his height being 5 feet, 3½ inches.

Although the treatment and rehabilitation of the paraplegic child is an arduous task, demanding meticulous attention to detail, as well as firmness and patience, the results possible are most rewarding.

(Article as originally published contained three case histories.)

Mother and Child, journal of the National Baby Welfare Council, is published monthly at 86 Tavistock House North, W.C. 1, London, England; subscription rate, 2s a copy.

795

Some Thoughts on Rehabilitation

By: **Sterling Brinkley, M.D.** *(Director, Gaylord Farm Rehabilitation Center, Wallingford, Conn.)*

In: *Workmen's Compensation Problems, Proceedings—45th Annual Convention of the International Association of Industrial Accident Boards and Commissions, Boston, Mass., September 27-October 1, 1959,* p. 54-58. *(Bul. 213, U.S. Dept. of Labor, Bur. of Labor Standards)* 1960. 234 p. U.S. Government Printing Office, Washington 25, D.C. 65¢.

IT IS ESTIMATED that industry loses $2 billion a year because of illness of 2 million employees and that employees' families lose 13 percent of their potential income for this same reason. A nonproductive or sick member of any community lowers its standard of living. Preventing or decreasing the duration or degree of illness of any community member increases its standard of living.

Three basic goals of rehabilitation are:

1. To help people of all ages and types of disability understand themselves, their circumstances, and their opportunities to improve these circumstances;

2. To help them want to realize these opportunities; and

3. To help them actually realize these opportunities by appropriate therapies, training, and direct assistance.

Rehabilitation starts when disability is recognized. In severe cases, the first objective is to help the patient care what happens. Other patients, a minister or priest, nurse, neighbor, social worker, physician, or attendant may provide courage, vision, and hope. Until he cares, too much attention and therapy may slow down rehabilitation.

Since throughout rehabilitation timing is essential, staff members must co-ordinate services. Leadership will vary depending on personalities and relationships—of the patient and the "team." Leadership of a social worker, nurse, therapist, minister, or counselor will be more effective at times than that of a physician.

Locating rehabilitation centers in rural areas with management by autonomous directors offers advantages over a center connected to a general hospital:

1. Patients have a better opportunity to get perspective about the assets and liabilities of their situation.

2. A "therapeutic community" of people and atmosphere can be developed.

3. The team can function more effectively because all their attention is directed to people with prolonged illness, in the acute as well as chronic phases.

4. The team is more cohesive—knows each other's abilities and can accept inter-relationships that are not necessarily the traditional roles of doctor, nurse, social worker, therapist, and attendant.

Since the concepts of rehabilitation differ somewhat from those of "traditional medicine," different staff relationships could well be more effective here. The person disabled and his motivations, abilities, and confidence rather than his disability determine whether he needs the services of a good doctor or those of a team of doctors, some of them medical specialists, social workers, nurses, physical, occupational, recreational, and work therapists, and vocational counselors.

The key to good teamwork, needed in rehabilitation, is communication. Leadership must recognize the value of others' suggestions, particularly the patient's. The common denominator of this team is interest in people. The staff always should strengthen the patient's family situation while they care for the patient himself—he must not be excluded from the family circle by new developments in it. His desire to get well depends on his expectations—whether he thinks he will be an asset or liability. This in turn is influenced by the family situation. If able the patient should do what he can for himself.

Unfortunately most chronically ill people are not wealthy. Rehabilitation team services are as expensive as they are effective. The cost depends on the number of people providing services—the cheaper the care, the fewer the staff, and the fewer the qualifications of the staff. In the long run, the most expensive care, measured by the cost per day, may be the most economical. How long a person is disabled and the residual degree of disability and the duration when the family costs are higher and income lower determine how much the economy of the family or community will be affected.

It is increasingly evident that federal, state, and local governments must furnish part or all of the services for some economic groups. Difficulties of financing will lead to inadequate care—pennywise and pound foolish.

A challenge to society is the increasing number of people, who, though disabled, could be rehabilitated to greater usefulness, if they had the will. Some of this "hard core" of the unfit may be motivated and rewarded for illness by compensation or welfare grants paid for "total

disability." Others are insecure people who desire independence but fear it more. Others have secondary gains in relationships to others, which are alleviated in their minds by illness. Sympathy for the partially disabled must not make disability profitable or desirable. Intelligence should supplement "faith, hope, and charity" to help these persons become more useful. When any member of the community is significantly upgraded by the coordinated efforts of rehabilitation, others less secure are encouraged to "give it a try." Centers have the challenge of upgrading patients referred for their own good and to develop this chain reaction.

Any chronic illness, mental or physical, has many more features in common than differences. Patients affect one another. Problems are not unique. The courage of others is often infectious.

Invariably, the physician is a key figure in the patient's rehabilitation: his thorough physical examination and history of patient experiences; his timed education—telling the patient what to expect—teaching him how to balance his life; his confidence and kind firmness; all of these are individually tailored to the patient. His humor may be particularly therapeutic.

Individuals may be the key to a patient's rehabilitation, but the team itself must work together smoothly. Understanding of how others in the team feel on common problems is one mechanism. Group sessions with a psychiatrist in discussion of a patient invariably have increased awareness of the problems faced by others of the team. Better understanding increases effectiveness.

In rehabilitation every attention must be given to prevention of disabilities. The great challenge of this new concept of medicine should be recognized and advantage taken of the outstanding opportunity to observe the natural history of diseases—research that is badly needed. Observation will lead to ever-improving methods of preventing these diseases and of treating and rehabilitating those affected. Our present facilities and program should be expanded and developed.

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Speech Science; Acoustics in Speech

By: **Richard A. Hoops**

1960. 137 p. figs., tabs. Charles C Thomas, Publ., 301-327 E. Lawrence Ave., Springfield, Ill. $4.75.

This concise report of research in experimental phonetics, presented in outline form for easier reading and comprehension, offers data on the physics of sound and voice production. The study aids and glossaries of terms following each chapter make the book especially useful as a textbook for students of speech therapy and audiology. Such speech disorders as pitch problems, hearing loss, and voice quality deviations are covered. Much of the data published previously in textbooks and journal articles has been brought together here; references appear as footnotes throughout the text, in addition to the separate bibliography of books and articles. Indexed.

793

Teaching the Mentally Retarded Child

By: **Natalie Perry**

1960. 282 p. illus. Columbia University Press, 2960 Broadway, New York 27, N.Y. $6.00.

Programs and teaching technics, theory and practical suggestions, teaching aids, and a host of activities for training the severely mentally retarded (trainable) child in the home, school, and community are discussed realistically by a teacher with more than 20 years' experience in the field. Parents and professional workers with the retarded can profit from Miss Perry's suggestions on the management of home-school and school-community relationships, the development of program activities in physical training, self-care, self-expression, and vocational education, and the necessary qualifications for teachers of trainable children. Additional aids are the short bibliographies following each chapter, the sample record forms, class schedules for children at various levels of achievement, selected lists of educational materials, activities classified according to use, and books for children. Includes a general index and an index to crafts and games described throughout the book.

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burner units from the oven section. Burner units should be placed at the front of the range instead of back of each other. The drop-hinged oven door is a safety hazard. Low broilers are difficult to use. Control panels must be on the front of the range or oven instead of on the hard-to-reach back wall. The open flame gas ranges present the possibility of being burned and the problem of relighting the pilot light. Hence, electric ranges and ovens are recommended.

Drain pipes for the sink should be located in the back rather than towards the front as in standard sinks. This precaution prevents the hot pipes from burning the legs of the wheel chair person and provides the necessary open space for the knees.

Additional suggestions to ease the kitchen duties of the paraplegic woman are having any extra equipment on rollers, ice cube trays that fill automatically, and clothes driers that empty the lint down the drain instead of through a lint trap.

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

AMPUTATION—EQUIPMENT

796. Mary Free Bed Guild Children's Hospital and Orthopedic Center *(920 Cherry St., S.E., Grand Rapids 6, Mich.)*

Upper extremity prosthetic dictionary, by Aida Lund. Grand Rapids, The Hospital, 1960. (32) p.

First of its kind to be published, this alphabetical listing of terminology and abbreviations, with definitions, should prove useful in teaching and training therapists, medical personnel, and prosthetists working with the upper extremity amputee.

797. Prostheses, Braces, and Technical Aids. Spring, 1960. No. 7.

Partial contents: Prosthetic service in the Centre for the Disabled in Elisabethville, Congo, Dr. van der Elst.—Indication for application of the pneumatic arm prosthesis (part 2), Ernst Marquardt.—Factors governing the development of functional and rehabilitative devices for conditions affecting the upper-extremity, J. A. E. Gleave.

Two new designs for devices are described in "A new plastic brace," by E. Buttrup, and "'Kartex,' carrying device for severely handicapped," by Karl Kristensen. The journal is published by the International Society for the Rehabilitation of the Disabled's Committee on Prostheses, Braces, and Technical Aids.

798. Prostheses, Braces, and Technical Aids. Summer, 1960. No. 8.

Partial contents: Orthotics and prosthetics in the United States of America, Lester A. Smith.—"How I exploited the force of forearm muscle tension," Stefan Cieslewski.—Alterations and repairs on laminated plastic-sockets, Gotz-Gerd Kuhn.—Prosthetics in Spain, Pedro Prim.

Mr. Smith, executive director, American Orthotics and Prosthetics Assn., lists reference aids for visitors to the United States. Mr. Cieslewski, a double-arm amputee, tells how he performs any precision job without effort by using simple and convenient aids he has invented.

See also 823.

AMPUTATION—EQUIPMENT—RESEARCH

799. New York University

(Prosthetic and orthotic activities at. . . .) *Orthopedic & Prosthetic Appliance J.* Sept., 1960. 14:3:22-94.

Contents: Rehabilitation at New York University, Lester J. Evans.—Prosthetics research, Hector W. Kay.—Focus on orthotics, Edward Peizer.—The problem of predicting success in prosthetic rehabilitation, Samuel A. Weiss.—The role of the prosthetics consultant in amputee rehabilitation, William A. Tosberg.—Independence through equipment, Muriel E. Zimmerman.—Basic training in prosthetics and orthotics, Charles R. Goldstine.—Post-graduate training in prosthetics and orthotics, Norman Berger.—Professional education in prosthetics and orthotics, Sidney Fishman.

This is the first of three issues to be devoted to articles by university staffs; the University of California, Los Angeles, will contribute material for the March, 1961, issue and Northwestern University will be represented later in 1961.

AMPUTATION—PHYSICAL THERAPY

800. Knott, Margaret *(California Rehabilitation Center, Vallejo, Calif.)*

Facilitation technics in lower extremity amputations, by Margaret Knott and Sedgwick Mead. *Phys. Therapy Rev.* Aug., 1960. 40:8:587-589.

Advocates use of cold applications in conjunction with relaxation technics to increase range of motion in lower-extremity amputees. An exercise program using patterns of facilitation against maximal resistance should supplement this treatment; resistive balancing activities can be carried out before actual wearing of prostheses.

AMPUTATION (CONGENITAL)—BIOGRAPHY

See 783.

BLIND—SPECIAL EDUCATION

See 840; p. 334.

BRACES

801. Bennett, Robert L. *(Georgia Warm Springs Foundation, Warm Springs, Ga.)*

Use of orthetic devices in rehabilitation. *Rehab. Record.* July-Aug., 1960. 1:4:29-33.

A discussion of the need for and use of orthotic devices (braces, splints, supports, and wheel chairs) in severely disabled patients to assist in recovery and increase functional capacity. Functional problems of several types of patients are considered. 6 illustrations.

BRAILLE

802. Massey, Joyce *(Royal Natl. Institute for the Blind, 204 Great Portland St., London, W. 1, England)*

Braille graph paper in charting of strength/duration curves. *Physiotherapy.* Sept., 1960. 46:9:249-251.

Describes the design of a braille graph paper on which the blind physical therapist can record accurately a chart of the strength/duration muscle test. Directions are given for construction and use of the graph paper.

803. U. S. Library of Congress. Division for the Blind *(Washington 25, D.C.)*

Reading for profit; an annotated list of press braille

and talking books on vocational training, personal adjustment, and economic advancement. Washington, D.C., Library of Congress, 1960. 16 p.

Lists 142 books, all available on loan from regional libraries for the blind. Although vocational titles are emphasized, others helpful to self-understanding and constructive use of leisure are also included. Books are classified under the subject headings of: general vocational, general background, farming and gardening, law, home and family, personal adjustment, leisure time activities, and personal narratives.

The bibliography is distributed free; copies in braille will be available in the near future.

BRAIN INJURIES—DIAGNOSIS

804. Burks, Harold F. *(Gallatin City School District, Downey, Calif.)*

The hyperkinetic child. *Exceptional Children.* Sept., 1960. 27:1:18-26.

Describes a procedure used to screen out hyperkinetic children and analyzes evidence from experimental work conducted by the author that might point to an association between behavior symptoms and criteria of brain pathology. Theories on brain malfunction are examined for clues on its role in producing deviate conduct noted in the hyperkinetic child. The article summarizes several years' research in the field of brain impairment.

BRAIN INJURIES—PARENT EDUCATION

See 788.

CANCER—EMPLOYMENT

805. Vosburgh, B. L. *(1 River Rd., Schenectady 9, N.Y.)*

The cancer patient in industry, by B. L. Vosburgh and H. M. Rozendaal. *J. Occupational Med.* Sept., 1960. 2:9:432-434.

The classification and grading scheme for various forms of cancer could be an aid to management in considering employment of applicants with history of cancer. Five-year survival rates reported by experts in the specialty of cancer should also be considered. Employment is deemed justifiable in certain cases, criteria for which are given. Consequences of such decisions in terms of industry's interests are discussed.

CEREBRAL PALSY

806. Cerebral Palsy Bul. 1960. 2:2.

Partial contents: Obstetric viewpoint on cerebral palsy, James Walker.—Obstetrical features related to cerebral palsy, G. Gordon Lennon.—Comments on the papers of Prof. Walker and Prof. Lennon; Comment 1, A. V. Neale; Comment 2, Benjamin Pasamanick.—E.E.G. in cerebral palsy, Arne Lundervoold.—A cerebral palsy centre in the tropics, C. Elaine Field; A problem and some replies from: N. S. Alcock, Marcel d'Avignon, Mrs. D. P. Beaman, G. A. Pollock, Guy Tardieu, and Grace Woods, with a postscript from Dr. Field.—The new Mental Health Act, Robina S. Addis.—Research backed by the National Spastics Society, Alison D. MacDonald. (See also #845, this issue of *Rehab. Lit.*)

807. Spastics' Quart. Sept., 1960. 9:3.

Entire issue devoted to articles dealing with problems of the school leaver and young adult with cerebral palsy.

Contents: The spastic school leaver; employment prospects, Dorothy Hellings.—The further education and training of the school leaver and young adult with cerebral palsy, F. M. Heywood.—Welfare services and social problems of young adult spastics, Mavis N. Barrett.—Medical aspects of cerebral palsy in the young adult, C. D. S. Agassiz.

Spastics' Quarterly is published by the British Council for the Welfare of Spastics, 13 Suffolk St., Haymarket, London, S.W. 1, England, at an annual subscription rate of 5s.

CEREBRAL PALSY—CALIFORNIA

808. Cohen, Peter *(Dept. of Pediatrics, Univ. of California School of Medicine, San Francisco 22, Calif.)*

Cerebral palsy; a re-evaluation. *J. Chronic Diseases.* Aug., 1960. 12:2:265-272.

Specialized diagnostic centers, residential schools, special education, training facilities in public schools, and medical and surgical care for the cerebral palsied comprise the program developed in California since 1945. Experience in the program has shown traditional therapy will not solve problems of the cerebral palsied child and his family. Emotional factors may be most limiting in relation to eventual vocational placement and independence. Good social counseling and the development of more programs for the preschool child are required. Administration of California's program is discussed.

CEREBRAL PALSY—BIBLIOGRAPHY

809. Reid, L. Leon, comp.

An annotated bibliography of selected references in cerebral palsy for professional personnel and parents, compiled by L. Leon Reid, Melba M. Miller, and William G. Wolfe. Pittsburgh, Stanwix House, 1960. 84 p.

Some 600 briefly annotated references, listed alphabetically, have been compiled by three professional educators to aid in understanding of cerebral palsy. The topical index indicates references appropriate for parent or professional use; additional aids are an author index and a listing of journals from which references were taken (addresses are included).

Available from Stanwix House, 3020 Chartiers Ave., Pittsburgh 4, Pa., at $2.25 a copy.

CEREBRAL PALSY—BIOGRAPHY

See 782.

CEREBRAL PALSY—EMPLOYMENT

See 872; 875.

CEREBRAL PALSY—PHYSICAL THERAPY

810. Doman, Robert J. *(8801 Stenton Ave., Philadelphia 18, Pa.)*

Children with severe brain injuries; neurological organization in terms of mobility, by Robert J. Doman (and others). *J. Am. Med. Assn.* Sept. 17, 1960. 174:3:257-262.

Describes a new system of therapy developed over a two-year period with 76 brain-injured children treated in the Children's Clinic, Philadelphia. Nonwalking children spend all day on the floor and are encouraged to crawl or creep. Activity patterns (homolateral and cross-pattern) are administered several times daily. Programs for establishing laterality and improved breathing, and for sensory stimulation, are instituted. A developmental mobility scale describing 13 levels of normal development was used to evaluate progress. Results in this preliminary study, when compared with those obtained through use of classic therapy, were significant enough to warrant expanded and continued study of the procedures.

CEREBRAL THROMBOSIS

See 784.

CHRONIC DISEASE

811. Moskowitz, Eugene *(220 N. Columbus Ave., Mt. Vernon, N.Y.)*

A controlled study of the rehabilitation potential of nursing home residents, by Eugene Moskowitz (and others). *N.Y. State J. Med.* May 1, 1960. 60:9:1439-1444.

Data from a survey of 163 patients in 18 nursing homes. Observation during one year revealed the major rehabilitation need was to maintain or improve their activities of daily living. The county health department should develop an educational program to teach concepts of "dynamic custodial care" to professional personnel, attendants, and aides in nursing homes.

CHRONIC DISEASE—INSTITUTIONS

812. U. S. Public Health Service

Costs of operating nursing homes and related facilities; an annotated bibliography, prepared by Maurice E. Odoroff, Anna Mae Baney, and Anne B. Stageman. Washington, D.C., Govt. Print. Off., 1960. 38 p. tabs. *(Public Health Serv. publ. no. 754)*

The 59 references, covering proprietary, nonprofit, and public facilities, give data related to costs of providing care rather than charges for care. Two new sections cite material on accounting records and manuals of hospital accounting adaptable for nursing home use.

Available from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 20¢ a copy.

CHRONIC DISEASE—PROGRAMS

813. Association of State and Territorial Health Officers

The issues in chronic disease control. *Public Health Rep.* Sept., 1960. 75:9:827-834.

A brief summary of resolutions adopted at a joint conference meeting of State and Territorial Chronic Disease Program Directors with the Association of State and Territorial Health Officers, held in September, 1959. Such issues as program leadership, diabetes, nursing homes, homemaker services, participation in the White House Conference on Aging, disability, epidemiological approach to chronic disease control, and the role of social science workers were considered. Two papers, "Caring for the chronically ill in existing facilities," by John A. Cowan, and "The geriatric program in Santa Cruz, Calif.," by Russell S. Ferguson, are abstracted.

CHRONIC DISEASE—SURVEYS

814. Wenkert, Walter *(Council of Social Agencies, 70 N. Water St., Rochester 4, N.Y.)*

Methods and findings in a local chronic illness study, by Walter Wenkert and Milton Terris. *Am. J. Public Health.* Sept., 1960. 50:9:1288-1297.

A report of a study in Monroe County, N.Y., investigating care needs of persons being served by various institutions and agencies in the community (Rochester) and how well patients' needs were being met. Analysis of the findings was studied by the agencies and facilities involved who then made recommendations for improvement of services and co-ordination of community efforts in rehabilitation.

See also 847.

CLEFT PALATE—MEDICAL TREATMENT

815. Hagerty, Robert F. *(55 Doughty St., Charleston, S.C.)*

Mid-facial contour in patients with cleft lip and cleft palate, by Robert F. Hagerty and Milton J. Hill. *Pediatrics.* Sept., 1960. 26:3(Pt. I):387-396.

Reports an investigation supported by the National Institute for Dental Research to determine incidence of facial deformity resulting from cleft palate surgery. Contradictions in the literature concerning optimum time for surgery and technics to be used are cited. A detailed, statistically evaluated study of results in 99 patients leads the authors to believe that conventional palatal surgery can be performed before the end of the second year of life without detriment to facial contour. Maximal opportunity for development of good speech is afforded. 33 references.

CONGENITAL DEFECT

See 785.

DEAF

816. Alexander Graham Bell Association for the Deaf

Proceedings of the Summer Meeting of the . . . June 27-July 1, 1960. *Volta Rev.* Sept., 1960. 62:7:301-423.

Contains panel discussions on speech and language development held at the Summer Meeting, as well as papers given, by invitation, on recreation and social needs, parents' problems, curriculum development, education of the multiply handicapped, aphasia, research in education of the deaf, community programs, and guidance for deaf children.

Available from The Volta Bureau, 1537 35th St., N.W., Washington 7, D.C., at 50¢ a copy.

See also 781; 792.

DEAF—SPECIAL EDUCATION

See 789.

DEAF-BLIND

See p. 334.

DENTAL SERVICE

817. Sheldon, Marvin P. *(U.S. Public Health Service, Washington 25, D.C.)*

Community planning for dental care of the chronically ill and disabled. *Am. J. Public Health.* Sept., 1960. 50:9:1298-1303.

Planning community dental programs for the disabled requiring special consideration calls for identifying such groups of patients and co-ordinating efforts of community agencies, institutions, and the dental profession. Financing of care, training personnel, and administration of a comprehensive community program are considered. (See news item, *Rehab. Lit.*, June, 1960, p. 203.)

See also 846.

DIABETES—EMPLOYMENT

818. Engelhardt, Hugo T. *(Baylor Univ. Coll. of Medicine, Houston, Tex.)*

The diabetic *is* employable, by Hugo T. Engelhardt and Harvey B. Snyder. *J. Occupational Med.* Sept., 1960. 2:9:427-431.

With appropriate placement, the diabetic whose condition is well controlled can perform any type of work for which he is physically, educationally, and mentally prepared. Data from a survey of office personnel in a large industry illustrated successful work experience of a majority of the 23 persons with a definite history of diabetes. Factors to consider in present-day employment of diabetics are discussed.

DRIVERS

819. Gart, Walter

A comparison of severely handicapped and able-bodied drivers. *Accent on Living.* Fall, 1960. 5:2:11-12, 23.

Former students and alumni of the Student Rehabilitation Center, University of Illinois, were surveyed for information on their driving histories and use of hand controls. Motor-vehicle accident rates of severely handicapped drivers were sought from 25 insurance companies but were not available or classified separately. Road test results compared favorably with those of nonhandicapped drivers. Information was gathered by the author for a master's thesis (Univ. of Illinois, 1959).

Editorial office of *Accent on Living* is located at 802 Reinthaler St., Bloomington, Ill. (Single issues, 50¢; yearly subscription, $2.00)

EMPLOYMENT (INDUSTRIAL)

820. Schletzer, Vera M. *(Industrial Relations Center, Univ. of Minnesota, Minneapolis, Minn.)*

Labor market participation of physically handicapped persons in Minnesota. *Personnel and Guidance J.* Sept., 1960. 39:1:6-10.

Presents data from a study conducted by the Industrial Relations Center, Minneapolis, showing how the physically handicapped of Minnesota fare in the labor force. "Minnesota Studies in Vocational Rehabilitation: VII, Factors Related to Employment Success," from which the data are derived, was annotated in *Rehab. Lit.*, Sept., 1959, #722. (See also #863, this issue of *Rehab. Lit.*)

821. Thompson, Doris M. *(460 Park Ave., New York 22, N.Y.)*

A new look at Abilities, Inc. *Indust. Med. and Surg.* Sept., 1960. 29:9:413-418.

In same issue: Selection and placement of the handicapped worker, Harold E. Yuker, William J. Campbell, and J. R. Block. p. 419.—The above knee amputee, Alvin Slipyan. p. 422.—Employment of the physically handicapped; a survey of industrial plants in Atlanta, Georgia, E. T. Eggers. p. 427.

Physical and personnel problems peculiar to an industry manned entirely by the physically impaired have been handled in such a way that a high level of productivity, employment morale, and safety has resulted. Special safety features of plant design and arrangement, adapted equipment, job changes, and production incentives are discussed.

Dr. Yuker, research director of Human Resources Foundation (a division of Abilities, Inc., Albertson, N.Y.), and his associates discuss implications of their research findings in regard to the value of pre-employment screening devices. The medical director's responsibilities in employee selection are considered.

Dr. Slipyan, recently deceased medical director of Abilities, Inc., conducted fatigue studies, based on actual productive performance and general health of above-knee amputees. In his opinion these persons can equal work performance of nonamputees and do so without showing clinical manifestations of fatigue.

Company policies on employment of the physically handicapped were studied in 15 manufacturing firms by Mr. Eggers (*Georgia State College, Atlanta*); negative attitudes discussed here show need for better public education on the social, economic, and moral benefits of hiring the handicapped.

EPILEPSY—SURVEYS—GREAT BRITAIN

822. Great Britain. College of General Practitioners

A survey of the epilepsies in general practice; a report by the Research Committee of the. . . . *Brit. Med. J.* Aug. 6, 1960. 5196:416-422.

A statistical analysis of data from a survey of epilepsy made by 134 practitioners in England and Wales, Oct. 1, 1957-Sept. 30, 1958. Incidence, distribution by age and sex, employability, adequacy of seizure control, need for institutional care, prevalent pattern of treatment, and referral methods were investigated.

HAND—EQUIPMENT

823. Thompson, Robert G. *(720 N. Michigan Blvd., Chicago 11, Ill.)*

Prosthetic replacements for the partial hand amputee, by Robert G. Thompson and Michael M. Amrich. *Indust. Med. and Surg.* Sept., 1960. 29:9:399-404.

The types of partial hand amputations most commonly seen at Liberty Mutual Rehabilitation Center, Chicago, were reviewed in an attempt to supply practical and durable prostheses. Technics of the amputee clinic team in preprosthetic evaluation and in fabricating prostheses

are discussed in some detail. Steps in fabricating and fitting a variety of prostheses are outlined. Eleven case histories with illustrations are included.

HEART DISEASE—EMPLOYMENT

824. Cantoni, Louis J. *(Wayne State Univ., Coll. of Education, Detroit 2, Mich.)*

Can cardiacs work? *Voc. Guidance Quart.* Summer, 1960. 8:4:239-240.

A brief summary of recommendations made at a statewide conference of the Michigan Heart Association held at Wayne State University in November, 1959. Medical and vocational rehabilitation of the cardiac, problems related to workmen's compensation, and the role of the vocational counselor were considered.

HEMIPLEGIA—DIAGNOSIS

825. Ullman, Montague *(Bellevue Hosp., 26th and First Ave., New York, N.Y.)*

Motivational and structural factors in the denial of hemiplegia, by Montague Ullman (and others). *Arch. Neurology.* Sept., 1960. 3:3:306-318.

Four varieties of delusional responses observed in patients with strokes illustrate the differing equilibria between structural and motivational factors in the production of denial of hemiplegia. It is believed that behavioral responses signifying unawareness of illness or body parts are the result of perceptual alterations occurring in a milieu of diffuse brain dysfunction. A questionnaire survey of 34 patients manifesting no clinical signs of denial following occurrence of hemiplegia was analyzed and responses compared.

HEMIPLEGIA—EMPLOYMENT

See 777.

HEMIPLEGIA—MEDICAL TREATMENT

826. Casella, Carmine *(Elmhurst Gen. Hosp., 79-01 Broadway, Queens 73, N.Y.)*

A study to determine the "energizing" effects of iproniazid (Marsilid) on a group of hemiplegics, by Carmine Casella and Jack Sokolow. *Arch. Phys. Med. and Rehab.* Sept., 1960. 41:9:381-385.

Reports a pilot study of the effectiveness of the drug as a means of activating patients' participation in the rehabilitation process. Poorly motivated patients (60 males with hemiplegia on the right side) were divided into experimental and control groups. Significant gains of the experimental group were apparent in physical activity scores. Possible reasons for discrepancies between results of measures of overt and covert physical and psychological response in both groups are discussed.

See also 784.

HOME ECONOMICS

827. McCullough, Helen E.

Space and design requirements for wheelchair kitchens, by Helen E. McCullough and Mary B. Farnham. Urbana, Ill., Univ. of Illinois Agricultural Experiment Station, 1960. 47 p. illus., tabs., floor plans. *(Bul. 661)*

A report of a study made at the University of Illinois housing research laboratory with the aid of 20 physically handicapped women students and 6 physically handicapped women volunteers from the community. Purpose of the study was to determine definite dimensions needed for circulation space, range of access for storage, clearances for knees and chair arms, and comfortable work heights. Kitchen and laundry equipment was tested for ease of use. Three experimental kitchen arrangements, planned from the data, are included. Methods and equipment used are given in appendixes, along with forms for recording data. (See also p. 351, this issue of *Rehab. Lit.*) Another bulletin is being prepared to give specific kitchen layout for wheel chair use.

Available from the Information Office, Mumford Hall, University of Illinois, Urbana, Ill.

828. Parsons, Mabel H. *(Child Development Clinic, Iowa State Univ., Iowa City, Iowa)*

A home economist in service to families with mental retardation. *Children.* Sept.-Oct., 1960. 7:5:184-189.

An Iowa research project with a multidisciplinary team provides a variety of services to families where at least one parent and one child appear to be mentally retarded. The study hopes to determine the relation of social, economic, and educational deprivation to familial mental retardation. The author describes her role in the program and some interesting results of individual instruction and group activities.

HOSPITALS—PHYSICAL THERAPY DEPARTMENT

829. McMain, M. J. *(Harlow Wood Orthopaedic Hosp., Mansfield, Notts., England)*

The planning of hospital physiotherapy departments. *Physiotherapy.* Aug., 1960. 46:8:223-230.

A physical therapist with more than 25 years' experience outlines ideal facilities and conditions for the hospital physical therapy department, with special emphasis on the particular problems of installing and maintaining therapeutic pools. Includes a suggested layout for a remedial pool.

LIBRARY SERVICE

See 789.

MENTAL DEFECTIVES

See 828.

MENTAL DEFECTIVES—MISSOURI

830. Belinson, Louis *(Div. of Mental Diseases, Missouri Dept. of Public Health, Jefferson City, Mo.)*

Mental retardation in Missouri. *Mo. Med.* Sept., 1960. 57:9:1130-1135.

Reviews the extent of mental retardation as it exists nationally and in Missouri, current status of care in the state, and estimates of future needs. Data from reports of programs in Illinois and Pennsylvania are given, with program recommendations for each. A comprehensive plan for care of the mentally retarded is discussed; recommendations for legislative and community action for the coming biennium are included.

MENTAL DEFECTIVES—EMPLOYMENT

See 780; 874.

MENTAL DEFECTIVES—ETIOLOGY

831. Moncrief, Alan *(Institute of Child Health, Univ. of London, London, England)*

Biochemistry of mental defect. *Lancet.* Aug. 6, 1960. 7145:273-278.

An attempted classification and discussion of what appear to be examples of biochemically determined mental retardation in childhood. Treatment and preventive aspects have been considered where possible. Some efforts to estimate the size of the problem are cited.

MENTAL DEFECTIVES—INSTITUTIONS—GREAT BRITAIN

832. Stein, Zena *(Univ. of Manchester, Dept. of Soc. and Preventive Medicine, Manchester, England)*

Estimating hostel needs for backward citizens; a question of kinship, by Zena Stein and Mervyn Susser. *Lancet.* Aug. 27, 1960. 7148:486-488.

Random sampling of 106 men and women classed as educationally subnormal at school provided data on their social dependence and support from relatives. Subjects ranged in age from 20 to 24 years. Data were used to estimate, nationally, the type of institutional care needed, whether in hostels, hospitals, or disciplinary institutions. Variables affecting reliability of the tentative estimates are discussed.

MENTAL DEFECTIVES—NURSING CARE

833. Public Health News, N.J. State Dept. of Health. Sept., 1960. 41:9.

All papers in this issue, with the exception of Dr. Zindwer's foreword, were presented at the Mental Retardation Institute for Nurses, held at Rutgers University in March, 1960.

Contents: Introduction to lecture series, Renee Zindwer. —The problem of mental retardation, Rudolf P. Hormuth. —Medical aspects of mental retardation, Margaret Joan Giannini.—Social and cultural aspects of mental retardation, Edward Wellin.—The handicapped child and his concept of self, Harry V. Bice.—The parents' viewpoint, Elizabeth W. Boggs.—Home training of the mentally retarded child, Laura L. Dittman.—The public health nurse and the mentally retarded child, Gertrude Johnson. —Department of Institutions and Agencies' program for the mentally deficient, Maurice G. Kott.—Role of New Jersey Rehabilitation Commission in mental retardation, Beatrice Holderman.—Public school resources for retarded children in New Jersey, Boyd Nelson.—Role of New Jersey Association for Retarded Children, Inc., Theodore Lucas.

MENTAL DEFECTIVES—PSYCHOLOGICAL TESTS

834. Richey, Marjorie H. *(Muncie, Indiana)*

Psychological procedures in the diagnosis of mental retardation. *Exceptional Children.* Sept., 1960. 27:1: 6-10.

A guide for the clinical psychologist working in the school and community setting. Stressed are: need for differential diagnosis between mental retardation and mental deficiency; structuring the testing situation; a comprehensive battery of tests; a full case history; and clear-cut reports to the family and school personnel concerned.

MENTAL DEFECTIVES—SOCIAL SERVICE

835. Baker, Edith U. *(District of Columbia Dept. of Health, Div. of Maternal and Child Health, Washington 1, D.C.)*

Diagnostic and treatment services for the mentally retarded child. *Child Welfare.* Sept., 1960. 39:7:8-13.

Services of the Clinic for Mentally Retarded Children, established by the District of Columbia Department of Health in 1955, are described. The role of the social worker, especially, illustrates scope of the aid given parents and the child.

MENTAL DEFECTIVES—SPECIAL EDUCATION

836. Stein, Zena *(Manchester Univ., Manchester, England)*

Reading, reckoning, and special schooling among the mentally handicapped, by Zena Stein, Mervyn Susser, and E. A. Lunzer. *Lancet.* Aug. 6, 1960. 7145:305-307.

Follow-up testing of 49 men and women, age 20 to 24, formerly classed as educationally subnormal showed an association between attainment in reading and type of schooling, irrespective of clinical condition and family background. Special schooling seems of particular importance to those with Stanford Binet scores under 70, since, with it, many can achieve semiliteracy. Even this level of reading affords more social independence and a better chance to succeed at a job. A less obvious association between attainment in arithmetic and type of schooling was found; this holds only for those with IQ scores over 65. No conclusions were drawn in regard to teaching methods or segregation in special school.

See also 793; 857.

MENTAL DISEASE

837. Gelb, Lester A. *(400 First Ave., New York 10, N.Y.)*

Rehabilitation of mental patients in a comprehensive rehabilitation center. *N. Y. State J. Med.* Aug. 1, 1960. 60:15:2404-2411.

The psychiatric program at the Institute for the Crippled and Disabled, New York City, serves many considered to be severely ill. Problems in administering the program and results achieved with the first 18 patients admitted are discussed. Early indications of success suggest that a comprehensive program in rehabilitation centers and day hospitals could provide the full range of services needed by psychiatric patients.

See also 787.

MENTAL DISEASE—GREAT BRITAIN

838. Tibbits, J. C. N. *(All Saints' Hosp., Birmingham, England)*

A trial of discharge and aftercare of long-stay mental hospital patients, by J. C. N. Tibbits and W. B. Harbert. *Brit. Med. J.* Aug. 6, 1960. 5196:436-438.

A review of individual needs of 223 men in the chronic ward of a mental hospital in an English industrial city revealed 38 who could be discharged immediately. The hospital psychiatrist and a psychiatric social worker from the local health authority co-operated on aftercare plans to aid in transition to community life. Results of a three-year follow-up are discussed.

MONGOLISM

839. U. S. Children's Bureau

The mongoloid baby. Washington, D.C., Govt. Print. Off., 1960. 20 p. illus. *(Children's Bur. folder no. 50-1960)*

A pamphlet for parents, outlining problems they will face, sources of community help, and what may be expected of the child as he grows. Similar publications on children with other handicapping conditions are also available.

Order from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C., 10¢ a copy.

MULTIPLE HANDICAPS—SPECIAL EDUCATION

840. Huffman, Mildred B. *(California School for the Blind, 3001 Derby St., Berkeley 5, Calif.)*

Teaching retarded, disturbed blind children. *New Outlook for the Blind.* Sept., 1960. 54:7:237-239.

A teacher of the special primary class, California School for the Blind, discusses eight attitudes she believes teachers should consciously strive to develop; their importance in working with multiply handicapped children is stressed. Mrs. Huffman is the author of *Fun comes first for blind slow-learners,* published in 1957 by Charles C Thomas, Publisher. (See *Rehab. Lit.,* Feb., 1958, #232)

MULTIPLE SCLEROSIS—MEDICAL TREATMENT

841. Hess, George H. *(2704 Sunset Dr., Tacoma 6, Wash.)*

A successful treatment for multiple sclerosis patients. *Paraplegia News.* Aug. & Sept., 1960. 14:144 & 145. 2 pts.

Reprinted from: *Northwest Med.* 1959. 58:3:377-382.

Therapeutic management of multiple sclerosis, as practiced at St. Joseph's Hospital, Tacoma, is described. Over 3,000 patients have been served since the clinic opened in 1946. Physical therapy to meet individual needs, an exercise program, allergic desensitization, use of drugs, management in bladder care, and treatment of medical emergencies are discussed. The general practitioner is qualified to care for most problems presented by multiple sclerosis patients and is better able to meet their continued need for psychological support.

MULTIPLE SCLEROSIS—MENTAL HYGIENE

842. Arnaud, Sara H. *(Arsenal Family and Children's Center, 40th St. and Pennsylvania Ave., Pittsburgh 24, Pa.)*

Some psychological characteristics of children of multiple sclerotics. *Psychosom. Med.* Jan.-Feb., 1959. 21:1: 8-22.

A study of certain psychological characteristics of children subjected to stress caused by chronic illness in a parent confined at home appears to substantiate the hypothesis that such children do show affective and defensive reactions to a greater degree than children from homes without chronic illness. The paper is an abridgement of a doctoral dissertation (Graduate School, Boston University, 1957).

MULTIPLE SCLEROSIS—STATISTICS

843. Miller, Henry *(Royal Victoria Infirmary, Newcastle upon Tyne, England)*

Multiple sclerosis; a note on social incidence, by Henry Miller, Alan Ridley, and Kurt Schapira. *Brit. Med. J.* July 30, 1960. 5195:343-345.

A common impression among neurologists, that a relative preponderance of multiple sclerosis patients exists in higher income groups, suggested this study. Data from a survey of Northumberland and Durham suggest the validity of the class analysis. An earlier survey (1958), based on social status of patients dying of the disease, revealed no correlation of social class and incidence of multiple sclerosis. Further research is needed to test the theory.

MUSCULAR DYSTROPHY

844. Vignos, P. J., Jr. *(2065 Adelbert Rd., Cleveland 6, Ohio)*

Maintenance of ambulation in childhood muscular dystrophy, by P. J. Vignos, Jr., and K. C. Archibald. *J. Chronic Diseases.* Aug., 1960. 12:2:273-290.

Sixty patients with progressive muscular dystrophy of the childhood type were studied for periods up to five years; main focus of this article is on 26 patients who no longer walk independently. The authors believe loss of independent ambulation in muscular dystrophy occurs prematurely; factors interfering with the dystrophic child's motivation for walking are discussed. A rating scale for degree of severity of joint contractures, an outline of criteria for functional classification, and a scale for rating effect of emotional factors on ambulation are included.

NEUROLOGY—RESEARCH

845. Lesny, Ivan

Developmental disorders of the central nervous system; research reports given at the annual meeting of Czechoslovak Child Neurologists, Marienbad . . . June 11-12, 1959, reported by. . . . *Cerebral Palsy Bul.* 1960. 2:2:103-108.

Dr. Lesny of Prague abstracts 26 research reports some of which may appear in full in later issues of the *Cerebral Palsy Bulletin.*

OBSTETRICS

See 785.

OLD AGE

846. Van Gorden, Mary E. *(401 E. 2nd St., Duluth, Minn.)*

Occupational therapy in homes for the aged and nursing homes. *Hosp. Progress.* Aug., 1960. 41:8:74-77.

In same issue: The importance of dental care, Dorothea F. Radusch. p. 78—Licensure problems, John M. Mason. p. 81.

Occupational therapy in nursing homes provides therapeutic and recreational activities, aimed at restoring useful function, preventing further disability, and meeting psychosocial needs. If it is impossible for the home to provide a trained therapist, volunteers properly trained can administer a diversional activity program.

Dr. Radusch *(Minneapolis, Minn.)* discusses dental problems specific or peculiar to aged and chronically ill patients and the responsibilities of institutions in providing dental care for their patients.

Mr. Mason *(Board of Charities, Evangelical Lutheran Church, Minneapolis, Minn.)* emphasizes the need for flexibility in licensing procedures to provide for the wide variety of homes caring for aged and ill persons.

OLD AGE—INSTITUTIONS

847. Goldmann, Franz *(Council of Jewish Federations and Welfare Funds, 719 Seventh Ave., New York 19, N.Y.)*

Personal health services in homes for the aged. *Am. J. Public Health.* Sept., 1960. 50:9:1274-1287.

Findings from a research project investigating coordination of health services for long-term illness are presented. Seventy Jewish homes for the aged were surveyed by mail questionnaires; field studies of 11 yielded further data on facilities, equipment, staff, and services. Separate physical facilities for the well and for the sick aged population are recommended.

ORTHOPEDICS

848. Lippmann, Heinz *(1192 Park Ave., New York 28, N.Y.)*

Heterotopic ossification, a problem in rehabilitation medicine. *Arch. Phys. Med. and Rehab.* Aug., 1960. 41:8:351-353.

Theories on the pathogenesis of extraskeletal bone formation in man are examined; the author's experience with patients with chronic venous insufficiency and subcutaneous ossification of the legs is discussed. It is his impression that local edema is an important pathogenetic factor in heterotopic ossification. The rationale of early weight-bearing ambulation in the paraplegic to control periarticular edema is considered.

PARALYSIS AGITANS

849. Constable, Kate *(16 E. 84th St., New York 28, N.Y.)*

Parkinson's disease; its challenge and outlook. *J. Am. Med. Women's Assn.* Aug., 1960. 15:8:757-760.

A general discussion of the three distinct clinical forms of Parkinsonism, the physician's role in helping patients accept the diagnosis of chronic illness, the current use of drugs in management of the disease, and the rationale and procedures used in surgical treatment.

PARALYSIS AGITANS—MEDICAL TREATMENT

850. Lin, Tung Hui *(Dr. Irving S. Cooper, 50 Sutton Pl., New York 22, N.Y.)*

Relationship between candidacy and outcome in surgery for Parkinsonism, by Tung Hui Lin (and others). *Arch. Neurology.* Sept., 1960. 3:3:267-270.

In same issue: Percutaneous injection of the thalamus in Parkinsonism; a preliminary report: relief of bilateral facial grimaces, by Arthur Ecker and Theodore Perl. p. 271-278.

A comparative statistical study substantiated the importance of preoperative selection of patients for the achievement of better results in surgery. Satisfactory results were high among the unilateral and early Parkinson patients and fewer among the advanced deteriorated group. No correlation was noted between surgical results and chronological age, sex, or duration of the disease. Difference between thalamectomy and pallidectomy in their effects on Parkinsonism is discussed. Treatment of choice is thalamectomy.

Dr. Ecker *(407 University Ave., Syracuse 10, N.Y.)* and Dr. Perl describe a new method of injecting the region of the ventrolateral nucleus of the thalamus, used primarily to relieve contralateral rigidity and tremor. Injection technics, advantages of the method, and results in seven patients are discussed. Illustrated.

PARAPLEGIA—MEDICAL TREATMENT

851. Friedland, Fritz *(V.A. Hosp., Boston 30, Mass.)*

Rehabilitation of spinal cord injured patients. *J. Phys. and Mental Rehab.* July-Aug., 1960. 14:4:95-97, 112.

A general discussion of the medical, psychological, physical, social, and vocational aspects of rehabilitation of paraplegic and quadriplegic patients and the factors recognized as causes for failure to achieve rehabilitation.

See also 794.

PARTIALLY SIGHTED—SPECIAL EDUCATION

852. Wallace, Helen M. *(U.S. Children's Bur., Washington 25, D.C.)*

School services for partially seeing and blind children in urban areas. *Sight-Saving Rev.* Fall, 1959. 29:3: 160-165.

Another in the series of articles by Dr. Wallace analyzing data from a study of special education services in 106 large cities. Previous articles in the series were listed in *Rehab. Lit.*, Oct., 1960, #740.

See also 859.

PARTIALLY SIGHTED—SPECIAL EDUCATION—ILLINOIS

853. Karnes, Merle B. *(Off. of Special Education, Champaign Community Schools, Champaign, Ill.)*

Revitalizing and expanding services for the partially seeing. *Sight-Saving Rev.* Summer, 1960. 30:2:97-100.

A continuous program of interpretation of the partially

seeing child's needs to school personnel, parents, and the community has resulted in increased identification of visual handicaps and improvement of educational opportunities in the Champaign community schools. Currently, a resource room at the elementary level and itinerant service at the secondary level eliminate need for the special class.

PEDIATRICS

854. J. Chronic Diseases. Sept., 1960. 12:3.

Entire issue devoted to a symposium: Chronic diseases of childhood.

Contents: Introduction, Francis Scott Smyth (Special editor).—Chronic endocrinopathies in childhood, William A. Reilly.—Newer virus diseases in childhood, John M. Adams.—Chronic allergy; crippler and killer of children, Susan C. Dees.—Neurological diseases in childhood, Marit Skatvedt.—The community and the mentally retarded, Peter Cohen.—Infections in the newborn period, Moses Grossman.—Malignant disease in children, Nicholas L. Petrakis.—Diagnosis of anemia in childhood, Ralph O. Wallerstein and Paul M. Aggeler.—Metabolic diseases of childhood, John J. Hutchings.—Clinical evaluation of heart disease in children, Ellen Simpson.

Single issues of the *Journal of Chronic Diseases* are available from the publisher, the C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, Mo., at $2.00 a copy.

See also p. 345.

PHYSICAL EDUCATION—PERSONNEL

855. California Association for Health, Physical Education and Recreation

Projecting curricula development in school and hospital situations (panel discussion presented at . . . the Therapy Section, 27th annual state conference. . . April 9, 1960) *J. Phys. and Mental Rehab.* July-Aug., 1960. 14:4:98-102, 112.

Contents: Is there really a need? Carl E. Klafs.—Contributions of the undergraduate physical education institutions to intertherapy relations, Frank J. Bok.—The training of physical educators for rehabilitation, Rudolph Jahn.—A single goal and a dual approach in projecting curricula development in school and hospital situations, Carl Haven Young.

PHYSICAL EFFICIENCY

856. Kaplan, Lawrence I. *(55 Park Ave., New York 16, N.Y.)*

An approach to disability evaluation, by Lawrence I. Kaplan, Jerome S. Tobis, and Milton Lowenthal. *Arch. Phys. Med. and Rehab.* Aug., 1960. 41:8:337-345.

More objective measures are needed for evaluating function and change in function of chronically ill patients. Questions raised during a long-term study of nursing home patients' potentials for rehabilitation, conducted by New York Medical College, concerned current level of competency in medical evaluation and prognosis. The method proposed here was tested by several physiatrists on 60 chronic disease patients being treated at Bird S. Coler Hospital. Forms have been drawn up for major conditions seen in the geriatric nursing home population; experience with the method suggests further exploration and refinement of the technic are warranted.

857. U.S. Office of Education

Motor characteristics of the mentally retarded, by Robert J. Francis and G. Lawrence Rarick. Washington, D.C., Govt. Print. Off., 1960. 40 p. tabs., graphs. *(Cooperative research monograph no. 1)*

The first of the monograph series concerning projects conducted under the U.S. Office of Education's Cooperative Research program (see *Rehab. Lit.,* Aug., 1960, #615) presents findings from studies on gross motor abilities of mentally retarded children in public school special classes and of institutionalized children of low intelligence. Motor achievement levels by age and sex are compared with published norms on normal children. Relationship between intelligence and motor abilities in the retarded was also studied. 31 references.

Available from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 20¢ a copy.

See also 826; 844.

PHYSICAL THERAPY—ADMINISTRATION

See 802; 829.

POLIOMYELITIS—BIOGRAPHY

See 779; 786.

PSYCHOLOGY

858. Zane, Manuel D. *(New York Med. College, Flower & Fifth Ave. Hospitals, Fifth Ave. at 106th St., New York 29, N.Y.)*

Motivation in rehabilitation of the physically handicapped, by Manuel D. Zane and Milton Lowenthal. *Arch. Phys. Med. and Rehab.* Sept., 1960. 41:9:400-407.

A further development of the concept that therapeutic efforts affect the patient's motivation as well as his performance (see *Rehab. Lit.,* July, 1959, #585). Case histories of nine patients demonstrating poor motivation at some time during the rehabilitation program illustrate motivation varying with changes in performance as affected by therapeutic intervention.

See also 842; 862; p. 345.

READING

859. Cohoe, Edith *(Detroit Public Schools, Detroit, Mich.)*

Teaching reading to the partially seeing child. *Exceptional Children.* Sept., 1960. 27:1:11-17.

Newer methods of special education for the partially sighted child in the public school are discussed in regard to establishing reading readiness, providing reading aids and favorable conditions, procedures for developing comprehension in reading, and ways of relating reading to other language arts.

See also 836.

REHABILITATION

860. Mother and Child. July & Aug., 1960. 31:4 & 5.

Title of issues: The handicapped child in the community; 1. Mentally handicapped (July); 2. Physically handicapped (August).

Contents: (July) Introduction, M. Crozier.—Mentally handicapped children in the community, D. H. H. Thomas.—A comprehensive children's hospital, David Lawson.—The child guidance clinic, P. Holman.—The epileptic child, Sheridan Russell.—The Mental Health Act of 1959: 1. Possible effects on work in mental hospitals, K. A. H. Sykes; 2. Co-ordination of effort in implementing the new Act, J. S. Thomas.—Extract: Residential care of handicapped children, J. Tizard (*Brit. Med. J.*, Apr. 2, 1960).

(August) Introduction, Lord Verulam.—The management of the spinal paraplegic child, L. Guttmann (see this issue of *Rehab. Lit.*, #794).—The spastic child, C. D. S. Agassiz.—Heart and lung diseases in childhood, T. Oppe.—Congenital syphilitics and their place in the community, G. M. Sandes.—Learning to be members of a community, F. E. Ferguson-Bell.—The parent's viewpoint, by the mother of a physically handicapped child.—Holidays for handicapped children in camp; programme for the Junior Department of the British Red Cross Society.

REHABILITATION—HISTORY

861. Platt, Sir Harry

Pioneers of rehabilitation. *Rehabilitation.* July-Sept., 1960. 34:5-12.

The Third Dame Georgiana Buller Memorial Lecture. A well-known British orthopedic surgeon recalls Dame Buller's role in development of comprehensive rehabilitation services, traces "rehabilitation" as practiced in ancient times, and reviews modern developments during the 20th century, especially as observed in Great Britain. He recommends a central clearing house to act as an advisory or coordinating body for the great number of existing organizations active in the rehabilitation movement.

REHABILITATION—PROGRAMS

See 790.

REHABILITATION—RESEARCH

862. Highland View Hospital, Cleveland

Behavioral research in rehabilitation (abstracts from papers presented at the Cleveland Symposium on Behavioral Research, Nov., 1959). *Rehab. Record.* July-Aug., 1960. 1:4:15-27.

Contents: Distinguishing features of disabled clients, Morton Zivan.—Group testing as a research and clinical tool, W. E. Fordyce.—The seriously disturbed patient, Paul W. Pugh.—Suggested research into attitudes toward the disabled, J. E. Muthard.—Rehabilitation counseling internship; academic or practical? Richard T. Sidwell.—Problems in fund raising, Beatrice A. Wright.—Psychological stress of physical disability, Bernard J. Somers.

In addition, the symposium included panel discussions (not given here) on research, methodology, testing problems and procedures, and needs for future research.

REHABILITATION—SURVEYS—MINNESOTA

863. Carroll, Stephen J., Jr. *(Industrial Relations Center, Univ. of Minnesota, Minneapolis 14, Minn.)*

The institutionalized population in Minnesota. *Public Health Rep.* Sept., 1960. 75:9:823-826.

A 1958 questionnaire survey of all institutionalized handicapped persons in Minnesota demonstrated successfully the possibility of obtaining reasonably accurate disability statistics by this method. Data are analyzed by 14 broad disability categories and 3 major age categories. The study was one phase of broad investigations conducted by the Industrial Relations Center for the State Interim Commission on the Employment of the Handicapped (see *Rehab. Lit.*, Dec., 1958, #1300; Mar., 1959, #190 and 268; Sept., 1959, #722; and Aug., 1960, #610)

REHABILITATION CENTERS—ADMINISTRATION

864. Newell, Edward A. *(1511 N. Berkeley Ave., Dallas 3, Tex.)*

Ethical relationships between center and the medical profession. *Hearing News.* Sept., 1960. 28:5:13-14, 16, 18.

An analysis of eight major systems of medical referral and medical association to speech and hearing centers reveals need for improvement in such relationships and in patient care. The medical school affiliated center is regarded as most satisfactory from the standpoint of avoiding ethical problems. Responsibilities of the center to referring physicians in regard to services rendered are defined. Promotion of better professional relations and increased use of the center are discussed. The article is revised from a paper presented at the American Hearing Society's 1960 Conference.

865. Raymond, Ann, Sister *(St. Anthony's Hosp., Las Vegas, Nev.)*

Plan for a regional rehabilitation center. *Hospitals.* Sept. 1, 1960. 34:17:37-39, 97-98.

General organization of the Midland Rehabilitation Center, Billings, Mont., still in the process of development, illustrates how comprehensive rehabilitation services can be provided through community resources. Existing facilities at St. Vincent's Hospital, Billings, provide the basis for a comprehensive center. Efforts of nationally affiliated agencies and volunteer groups will be coordinated; the Montana Society for Crippled Children and Adults hopes to provide a work adjustment program as its contribution.

See also 778; 795; 812; 837; 876.

SHELTERED WORKSHOPS—ADMINISTRATION

866. National Institute on Workshop Standards *(1028 Connecticut Ave., N.W., Washington, D.C.)*

Experimental evaluative instrument based on standards for sheltered workshops recommended by . . . Nellie Zetta Thompson, Institute Director. Washington, D.C., The Institute, 1960. 84 p. graph, record form. Spiral binding. Paperbound.

This report, prepared for testing purposes only, is not to be regarded as a definitive statement of standards approved by any of the sponsoring associations. Issued for

use in further experimental development and for purposes of self-evaluation and self-improvement by individual workshops, it discusses how the procedure operates to identify weaknesses and strengths of the individual facility. The checklist provides a means of measuring graphically the program of services, administration, staff organization and operation, adequacy of the facility, and community relations. A bibliography of selected references and a glossary of terms are included.

Sponsored by the National Association of Sheltered Workshops and Homebound Programs, National Rehabilitation Association, and U.S. Office of Vocational Rehabilitation, the manual is to be distributed on a limited basis only to agencies and individuals who participated in its development and who will continue to be involved in its further refinement and testing.

See also 873.

SOCIAL SECURITY ACT

867. Soc. Security Bul. Aug., 1960. 23:8.

Title of issue: Anniversary issue: The Social Security Act; its first twenty-five years.

Contents: Social security today and tomorrow, Arthur S. Flemming.—Past and future perspectives in social security, William L. Mitchell.—Social security status of the American people, Ida C. Merriam.—Old-age, survivors, and disability insurance after twenty-five years, Victor Christgau.—Twenty-five years of public assistance, Kathryn D. Goodwin.—Title V of the Social Security Act; what it has meant to children, Katherine B. Oettinger.—Twenty-five years of unemployment insurance in the United States, R. Gordon Wagenet.—A quarter century of social security abroad.—Significant events, 1935-60.—References on the origin and development of social security in the United States.

See also 791.

SPECIAL EDUCATION—EQUIPMENT

868. Stolurow, Lawrence M. *(809 Dodds Dr., Champaign, Ill.)*

Teaching machines and special education. *Educ. and Psych. Measurement.* Autumn, 1960. 20:3:429-448.

Psychologists, engineers, and education personnel are considering the possibilities of automation as a teaching aid. The author traces the early history of teaching machines, discusses eight functions of such devices important from the psychological viewpoint, and summarizes preliminary research findings on their use in special education. Specific problems that teaching machines might be used to investigate in education of the mentally retarded are indicated. 38 references.

SPEECH CORRECTION

869. American Speech and Hearing Association

Abstracts of the 36th Annual Convention, November 1-5, 1960. *Asha.* Oct., 1960. 2:10:323-379.

Papers prepared for the convention to be held in November and abstracted here cover organic and nonorganic speech and hearing disorders, audiology, aphasia, cleft palate, and speech and hearing disorders in relation to neurological conditions, mental retardation, and geriatrics patients. Parent education, community services, and training programs for speech and hearing therapists were also considered. A majority of the papers report findings of research in the fields of therapy and rehabilitation.

Single copies of *Asha* may be ordered from the American Speech and Hearing Association, 1001 Connecticut Ave., N.W., Washington 6, D.C., at 75¢ each.

See also 776; 792.

SPEECH CORRECTION—ADMINISTRATION

870. Lillywhite, Herold *(Univ. of Oregon Med. School, Portland, Ore.)*

Organizing a hospital program for communicative disorders. *Hospitals.* Sept. 16, 1960. 34:18:60-64, 93-94.

The concept of treating the whole person has led hospitals to recognize need for programs to diagnose and treat hearing, speech, and language problems of hospitalized patients. Types of patients, personnel required, administration of a program tailored to the hospital's services, and the necessity of employing fully qualified personnel are discussed.

VISION

871. Sheridan, Mary D.

Vision screening of very young or handicapped children. *Brit. Med. J.* Aug. 6, 1960. 5196:453-456.

Describes a graded series of simple clinical vision tests useful in working with children from 1¾ years through 7 years. The tests may also be used with the deaf, partially sighted, mentally retarded, cerebral palsied, and those with multiple handicaps. Equipment and testing procedures are discussed.

VOCATIONAL GUIDANCE

872. Allen, Robert M., ed.

Proceedings of the second annual workshop on the integration and interpretation of pre-vocational and vocational information concerning the neurologically handicapped client . . . held at the United Cerebral Palsy Rehabilitation Center of Miami, June 6 to 10, 1960 . . . ed. by Robert M. Allen, Christopher C. Corrie, and Thomas W. Jefferson. . . . Coral Gables, Fla., University of Miami Press, 1960. 43 p.

Discussion at the Workshop meetings centered around the medical, social, educational, and psychological problems faced by the vocational counselor in dealing with the neurologically handicapped client.

Contents: Panel discussion: National, state, and local needs for the training and rehabilitation of the neurologically handicapped, Darrell J. Mase, Moderator.—Current developments in diagnosing and counseling of the neurologically disabled, Salvatore G. DiMichael.—Counseling and guidance of the vocationally handicapped adolescent, Andrew M. Perryman.—Psychological rehabilitation program of the Coral Gables VA Hospital: I. Charles A. Stenger and Mabel K. Gibby; II. William C. Fleming.—Adjustment of the neurologically impaired, Harold Michal-Smith.—Vocational rehabilitation of the mentally retarded, Edward L. Miller.

Published by the University of Miami Press, Coral Gables 46, Florida.

873. Lenard, Henry M. *(Work Adjustment Center, 407 E. Michigan St., Milwaukee 2, Wis.)*

Supportive placement for the mentally retarded. *J. Rehab.* Sept.-Oct., 1960. 26:5:16-17.

Inadequate and impaired coworker relationships are found to be a significant factor in job failures for the majority of retarded workshop clients. When two clients were placed in the same work environment, each provided a supporting relationship for the other, was happier, and experienced more pleasure in holding the job. Group counseling has been intensified for re-entry cases at the Workshop, to overcome failures in the social sphere.

874. Lurie, Walter A. *(Natl. Conference of Jewish Communal Service, 150 E. 35th St., New York 16, N.Y.)*

An intensive vocational counseling program for slow learners in high school, by Walter A. Lurie, Jacob Goldfein, and Roland Baxt. *Personnel and Guidance J.* Sept., 1960. 39:1:21-29.

A report of a demonstration project conducted by the Federation Employment and Guidance Service, New York City, to determine the value of highly individualized vocational counseling services to slow learners. The report was originally issued by the Service in pamphlet form (see *Rehab. Lit.*, Nov., 1959, #873).

875. Machek, Otakar *(634 N. Grand Blvd., St. Louis 3, Mo.)*

Preliminary report of evaluating and classifying the vocational potential of the cerebral palsied, by Otakar Machek and Hardin A. Collins. *Arch. Phys. Med. and Rehab.* Oct., 1960. 41:10:434-437.

This report of a medically supervised, vocationally oriented program for young adults with cerebral palsy at United Cerebral Palsy's Youth and Adult Center, St. Louis, supports findings of other investigators—that those with cerebral palsy have less potential for vocational rehabilitation than those with other disabilities. On initial screening, only 46 of 102 persons applying for admission to the program were considered to have vocational potential. The analysis of results is based on experience with 29 persons who completed the program. Emotional stability and motivations were found to be more important in influencing outcome of rehabilitation than IQ or job sample performance. Low level of maturity, inability to accept himself, and an unrealistic attitude toward employment lower the cerebral palsied person's chance for vocational rehabilitation.

876. Manheimer, Robert H. *(Arthritis and Rheumatism Foundation, 432 Park Ave South, New York, N.Y.)*

Hospital-centered vocational rehabilitation, by Robert H. Manheimer (and others). *Arch. Phys. Med. and Rehab.* Oct., 1960. 41:10:446-451.

A Vocational Rehabilitation Service, operating as an integral part of the department of physical medicine and rehabilitation at Long Island Jewish Hospital, provides on-the-job evaluation of work skills, on-the-job training, and intensive placement aid for patients. This 240-bed suburban community hospital uses jobs within the hospital operation in its testing and training program. Of the 91 handicapped persons referred to the project in its first 14 months, cases of 51 have been closed, including 29 who went to work. Use of jobs in the hospital has proved administratively feasible and vocationally effective.

877. U.S. Office of Vocational Rehabilitation

The placement process in vocational rehabilitation counseling; compiled from proceedings of guidance, training, and placement workshops; ed. by Bruce Thomason and Albert M. Barrett. . . . Washington, D.C., Govt. Print. Off., 1960. 104 p. *(GTP Bul. no. 2; Rehab. Serv. ser. no. 545)*

Prepared for use as a textbook in state agency inservice training programs and in graduate training of counselors for the rehabilitation field, this booklet discusses technics of client evaluation, prevocational training, placement, and follow-up. Public relations aspects of placement are stressed. Note is made of special problems in regard to placement of the blind, mentally retarded, and exmental patients. A bibliography of 25 references is included. The material was developed by personnel of State vocational rehabilitation agencies and Office of Vocational Rehabilitation staff in workshops held over the past 13 years. The first booklet in this series, "Casework performance in vocational rehabilitation," was listed in *Rehab. Lit.*, July, 1959, #601.

Available from Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., at 35¢ a copy.

See also 780; 803; 807.

WORKMEN'S COMPENSATION—NEW YORK

878. Reed, Louis S. *(Sloan Inst. of Hospital Admin., Cornell Univ., Ithaca, N.Y.)*

Medical care and rehabilitation under the New York workmen's compensation program. *Am. J. Public Health.* Sept., 1960. 50:9:1264-1273.

Although New York's program compares favorably with those in other states in regard to workers covered, completeness of medical care provided, and level of benefits, findings of the author's six-month study support his contention that it could be more economically and effectively administered by the government, with no private carriers. Comparisons are made between New York's program and that operating in Ontario (Canada). Recommendations for improving the system are offered.

National Health Survey Reports Disability in Older Persons

THE U.S. NATIONAL Health Survey estimated that about 77 percent of persons 65 years and older had one or more chronic conditions, 42 percent having some degree of chronic activity limitation and about 18 percent chronic mobility limitation.

Activity limitation was increasingly higher in percentage as population density decreased and lower with increased family income. About 23 percent of this age group who were "usually working" had some degree of chronic activity limitation, compared with 36 percent of those mainly keeping house and 55 percent of retired persons. The percentage was higher in those classed as "other" in status, probably due to those unable to work during the past year but not retired. About 40 percent of those living alone or with nonrelatives had partial or major limitation of activity, as did about the same number of those married, living with relatives. However, 48 percent of those with other marital status, living with relatives, had some degree of activity limitation.

Limitation of mobility was reported in 16 percent of those living alone or with nonrelatives, 15 percent of those married, living with relatives, and 27 percent of those with other marital status, living with relatives.

Restricted-activity days averaged 625 million per year and bed-disability days 209 million, averaging 42.6 restricted-activity days per person per year, of which 14.2 were days of bed disability. Restricted activity and bed disability were higher for females than for males. The number of days of restricted activity and bed disability showed a marked increase as family income declined. Persons "usually working" (predominately male) averaged 23.3 days of restricted activity, with 5.2 days involving bed disability, while those mainly keeping house (more females) averaged 39.9 and 11.0 days. Disability rates for those retired or in "other" categories were considerably higher.

The highest rate of work loss, 13.6 days per "usually working" person per year was among those with family income of less than $2,000, while the lowest rate of work loss, 8.5 days, was for those earning $7,000 or more.—*From* Health Statistics from the U.S. National Health Survey: Older Persons, Selected Health Characteristics, United States, July 1957-June 1959 (Series C-no. 4), *U. S. Public Health Service, Washington, D.C. September, 1960. Available from U.S. Superintendent of Documents, Washington 25, D.C., at 45¢ a copy.*

NIH Health Research And Construction Grants Reported for Fiscal 1960

THE NATIONAL Institutes of Health, Bethesda 14, Md., awarded 11,743 grants totaling $229,505,503 for research and for construction of research facilities in nonfederal institutions during the fiscal year ended June 30, 1960. About 87 percent, or $198,719,397, went for support of 11,572 research projects concerned with major diseases and basic problems in the medical and biological sciences. These grants were made to 973 institutions in the United States and to 145 institutions in 38 other countries. Grants to help build, equip, or expand 171 research facilities, totaling $30,786,106, were awarded on a matching basis to 141 institutions in the United States. (*See table below.*)

A 445-page volume, *Public Health Service Grants and Awards by the National Institutes of Health, Fiscal Year 1960, Part I (Public Health Serv. publ. 777, Pt. I)*, listing the health research facilities construction and research projects grants by state and institution is available from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., at $1.25 a copy. A companion report on the research fellowships, training grants, and traineeships awarded by the NIH during the last fiscal year will soon be available.

Summary of Extramural Programs Appearing in Part I

Source of Support	Health research facility grants		Research projects grants	
	No.	Dollars	No.	Dollars
TOTAL	171	30,786,106	11,572	198,719,397
Institutes:				
Allergy and Infectious Diseases	.....	.....	1,508	21,056,625
Arthritis and Metabolic Diseases	.....	.....	2,083	30,729,199
Cancer	.....	.....	1,793	34,370,440
Dental Research	.....	.....	372	4,508,299
Heart	.....	.....	2,064	35,947,109
Mental Health	.....	.....	1,182	22,808,798
Neurological Diseases and Blindness	.....	.....	1,209	23,280,741
Division of General Medical Sciences	.....	.....	1,361	26,018,186
Division of Research Grants	171	30,786,106	.....	.....

Midwestern University To Serve Handicapped Student

THE UNIVERSITY of Missouri has been selected for a research and demonstration project in the education of the physically handicapped college student. The five-year program, financed by a grant of $700,000 from the U.S. Office of Vocational Rehabilitation, will serve Region #6, comprising the seven-state area of Missouri, Iowa, Minnesota, North and South Dakota, Nebraska, and Kansas. For the first year, starting Sept. 1, 1960, the University has been allotted $122,937 and is contributing an additional $39,450. Necessary modification of the campus and buildings will permit registration of handicapped students for the fall semester of 1962.

Dr. Samuel Kirk Comments

Public Ahead of the Professionals

"THE PUBLIC has gone so fast in their demands on what should be done with the mentally retarded in all areas—medical, social, educational and otherwise—that today we find not so much a cultural lag, but really a professional lag. Those of us in the professional field find ourselves so overwhelmed with not only demands but sometimes support that we don't have the people today to handle this at a high professional level; and I think that can be said for all the professional groups rather than just one of them."—*Samuel Kirk, Ph.D., as quoted in* Annual Report, New York State Joint Legislative Committee on Mental Retardation, March 15, 1960. *(Legislative Document (1960) no. 29) 63 p. Issued by the Committee's Chairman, State Senator Earl W. Brydges, Room 504, State Capitol, Albany, N.Y.*

American Nurses' Association Issues Statement of Standards For Care in Nursing Homes

A STATEMENT of Standards for Nursing Care in Nursing Homes was issued August 15 by the American Nurses' Association (10 Columbus Circle, New York 19, N.Y.) as a basis for improving patient care in these institutions. The ANA statement declares skilled nursing care—including its preventive, curative, and rehabilitative aspects—is a necessity in a nursing home. To provide skilled nursing care, *all* nursing homes should provide *direct supervision* of nursing care by a qualified, registered professional nurse, the statement continues.

According to the U.S. Public Health Service, 450,000 aged and chronically ill patients are now in 25,000 nursing homes in the United States and the number of both patients and nursing homes is increasing steadily. Only about one-third of the homes have a registered nurse or a practical nurse on their staff.

Over 90 percent of nursing homes are operated under private commercial ownership. The executive secretary of the Association, Mrs. Judith G. Whitaker stated, "The American Nurses' Association believes that nursing homes should be licensed and periodically evaluated by an official state agency in which the professional knowledge of medical and nursing personnel is available. A qualified registered nurse should be assigned by this state agency for the purpose of evaluating the nursing care in the nursing homes."

The ANA Statement of Standards for Nursing Care in Nursing Homes has been sent to the U.S. Department of Health, Education, and Welfare for use in a planned guide on standards for nursing homes that is to be released to state licensing agencies later this year. The ANA statement will also be supplied to state and local governmental departments that license nursing homes. Copies are available from the Association for 10¢.

Dr. von Werssowetz Comments on

The Physician's Use Of Rehabilitation

"REHABILITATION is variously defined, but in general it is a planned attempt by use of all available means to restore or improve the health, usefulness, and happiness of those who have suffered injury or who are recovering from disease.

". . . Although provision of rehabilitation is often complex, it can be conducted effectively at home or on the community level in most cases. The physician must see that the patient receives the necessary rehabilitative services, which he should prescribe individually and specifically.

"Important points in prescription of any rehabilitation program are:

"1. That it should be progressive, but kept well within the limits of endurance and fatigue of the patient, increasing in content and strenuousness as the patient begins to recover.

"2. That the methods and techniques used should be well balanced and adequately administered.

"3. That the program should provide for periods of mental relaxation and recreation.

"4. That it should be under close medical supervision.

"5. That it should be started early to prevent severe impairment and deformities.

"The physician should ascertain that auxiliary personnel have had adequate training and experience to administer prescribed procedures.

". . . As with any other medical or surgical treatment, a rehabilitation procedure should be applied with understanding of expected benefits and limitations. Every physician should use these methods when indicated, starting them early at the bedside, and continuing them long enough to restore the patient to the fullest functional ability of which he is capable. This is often a long and arduous task that requires patience and understanding on the part of the physician, who must provide encouragement and motivation to his patient."—*From "The Use of Rehabilitation," an editorial by Odon F. von Werssowetz, M.D., p. 706-707, in the September, 1960, issue of* Texas State Journal of Medicine.

A Comment on

The Administrative Method

"SUCCESSFUL administration is the creation of an environment—of an appropriate physical setting, of a favorable psychological climate, and of an established pattern for the interpersonal relationships required for the efficient discharge of an organization's function. Pioneers became administrators when they thoughtfully asked one another, 'How are we to settle this new land?' The hospital superintendent who convinces the legislature of the need for a new research building, who advises the architects on required facilities, who makes the final decision regarding the number and qualifications of personnel necessary in its staffing, who determines that the physician in charge shall report to the clinical director rather than to the business manager, who refuses to discharge a capable technician at the request of a spoils politician—a superintendent who deals purposefully with such issues—is involved in the most literal sense in the creation of an environment, and so, in administration."—*From* Administration of the Public Psychiatric Hospital, *p. 123, formulated by the Committee on Hospitals, Group for the Advancement of Psychiatry. Report no. 46. 1960. 79 p. Available from Publications Office, Group for the Advancement of Psychiatry, 104 E. 25th St., New York 10, N.Y., 1-9 copies $1.00 each, 10-99 copies 80¢ each, 100 or more copies 60¢ each.*

Dr. Meng Comments on

Recreation and the Handicapped

"TO MAKE appropriate therapeutic use of himself, it isn't necessary for the professional recreator to know a great deal about sickness. Nor is it necessary that he be a psychoanalytically oriented psychotherapist. What he does need to know is enough about the structure and function of the human body to understand how people run, eat, sleep, listen, see, feel, and so on. Recreators also need to have a good working knowledge of human personality, its development, and the dynamics of human behavior. This should be built into the recreator's professional perspective. . . .

"Whenever a person is ill, fatigued, hungry, or in any way out of sorts he becomes less capable of participation and more absorbed in his own processes. When illness, fatigue, or other type of disease is prolonged he regresses to further self-absorption and becomes unable to participate in 'other' activity.

"Although physical handicaps may call for activities of a specifically physiotherapeutic character, the basic problem of teaching the physically handicapped to recreate (I would prefer to say create) is essentially a psychiatric-mental health problem. I will even go further: learning about the joy of living is essential for all people, regardless of their handicaps. And we all have some. To show us that our potential for self-expression and satisfaction makes our handicap really unimportant, is, perhaps, the major task all recreators must perform for all the people with whom they work."—*From "The Recreator—Therapist or Therapeutic Agent?" by Ralph W. Meng, M.D., p. 360, in the October, 1960, issue of* Recreation.

Hearing Research Laboratory To Be Built at University of Michigan

THE WORLD'S largest laboratory devoted exclusively to research on hearing is planned at the University of Michigan Medical Center. A grant for $200,000 has been initially given by the Kresge Foundation of Detroit. The building is to be completed during the academic year 1962-63 and will be known as the Kresge Hearing Research Institute. Plans call for a five-story wing to be added to the Kresge Medical Research Building. It will connect with the 1,050-bed University Hospital and will be adjacent to the Medical School and School of Nursing. Extensive work will be done with patients, but the institute will be designed chiefly to advance knowledge of hearing through a broad, multidisciplinary attack on scientific problems. The University's Board of Regents will appoint a director for the Institute this fall.

Over the past seven years, the Kresge Foundation has contributed almost $5½ million to medical research facilities at the University.

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